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ABSTRACT

This manual is designed to help school district personnel assess the extent of substance abuse and to develop policies and procedures for dealing with the problem through the cooperation of schools, parents and communities. The effect of social change on adolescents is discussed and trends in developmental distress are noted. Roles and responsibilities of school personnel are outlined including curriculum considerations and objectives. A section on needs assessment is provided along with sample evaluation forms and questionnaires. The guide includes background information on smoking, drinking, and drug use, and developmental characteristics of adolescents. A wide variety of preventive programs are discussed in detail with names and addresses of resource groups and organizations. A bibliography of resource materials is also included. (JAC)

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ATTAINABLE ALTERNATIVES

DECISIONS FOR THE 80'S

A DISTRICT MANUAL ON SUBSTANCE USE, ABUSE, AND PREVENTION

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

This curriculum guide was developed during the summer of 1981 as a part of a Cortland-Madison BOCES sponsored Summer Curriculum Project.

PERHAPS THE BEST PREVENTIVE DRUG EDUCATION
PROGRAM DOES NOT MENTION DRUGS AT ALL

DR. HELEN NOWLIS

Cover Credits

The cover for this manual was designed and drawn by Robin Jackson based on the suggested concepts and theme proposed by the project participants. It reflects comprehensive and ongoing decision making process aimed at attainable alternatives to substance use and abuse.

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FOREWARD

The flower children and hippies of the 60's were here and gone by the early 1970's when the media and general public finally began to perceive the drug crisis among America's youth. Shocked by such illicit drug use, this nation poured millions of dollars into treatment and rehabilitation of drug abusers and a pittance, by comparison, into truly preventive endeavors.

The late 70's witnessed school personnel becoming increasingly bogged down in handling scholastic and disciplinary problems associated with substance use and abuse. A small minority, though negative segment, of the school population was commanding the almost undivided attention of school personnel. This left little time, by comparison, for recognition of the accomplishment of the majority of other fine individuals within the school.

Lyrics to the drug dilemma tune had been changed. Schools were emphasizing the negative and eliminating some of the positive that would have followed had they taken a stand on the issue, affirmed it publicly, asserted it positively, and recognized that long and broad range approaches were needed.

Instant solutions evaporated! Groups of sincere poeple, all interested in the same goal, became fragmented! All across the nation, symptoms of widespread drug use reared their heads among younger and younger age groups: poor school performance, truancy, school violence and vandalism, droupouts, runaways, and teen pregnancies to mention but a few.

Subsequently social science research, unable to establish actual causes of substance abuse, revealed reliable evidence of links with a variety of correlates:

- low self-esteem
- other destructive behaviors such as truancy and vandalism
- family conflicts
- negative peer pressure
- a sense of powerlessness
- poor interpersonal and social skills
- poor school performance

The reader might wish at this juncture to consult the following table for a summary of the factors or symptoms a school might address and the action or response the school might institute in its prevention efforts.

SYMPTOM/RESPONSE TABLE

Factors/Symptoms	Response/Action
Inability of youth and/or adults to communicate effectively.	Education in communication skills.
Feelings of powerlessness, a sense of not being in control of one's own life.	Education on problem-solving decision-making skills.
Confusion in the face of a rapidly changing world.	Reassessment and clarification of value systems.
Lack of challenge, of interest in life' boredom, ennui.	Offering of alternative pursuits to open up new fields of interests, new perspectives.

Various sections of Attainable Alternatives will address the issues highlighted above. In this manual, the school district will find the direction and materials it will need to set a new pace in its war against substance abuse.

Now, try to recall the wisdom, in terms of prevention of substance abuse, in the original lyrics of that tune of yesteryear:

> Accentuate the positive
> Eliminate the negative
> Latch on to the affirmative
> And don't mess with mister in-between.

With these thoughts in mind, progressive schools of the early 1980's are beginning to recognize the value of striving to prevent substance abuse by providing healthy role models and creating positive environments for learning, growing, loving, and living. Truly effective prevention programs will foster and maintain a level of individual achievement of self-fulfillment and self-awareness incompatible with substance abuse!

OVERVIEW

Attainable Alternatives: Decisions for the 80's is the end product of a two-week summer workshop funded by four, concerned local school districts and sponsored by the Cortland-Madison BOCES. It reflects the concerted efforts of many persons. The knowledge, dedication and expertise of the individual manual developer/writers are most worthy of recognition.

The manual is designed to assist school districts in:

1. Determining the extent of the substance abuse situation within their individual districts/communities as a basis for future evaluation of program progress and success.
2. Developing and implementing appropriate and workable policies and procedures for dealing with all aspects of substance abuse.
3. Increasing parental and staff awareness of the problems associated with substance abuse.
4. Providing parents and staff with current and accurate information, materials, and skills regarding drug abuse behaviors of students.
5. Seeking out recommended community based programs and resources which could be adjuncts to their own efforts.
6. Encouraging attainable alternatives to meeting human needs which are prevention oriented.

Project participants envision the manual as follows:

Comprehensive;

Useable with and by all persons involved with children of all school ages.

Integrated into all subject areas and levels of responsibility with the school.

Encompassing parental and community involvement

Flexible

Useable in any size district represented by the project participants

Applicable to urban or rural communities

Acceptable to public parochial or private schools within the communities

Practical

Requires a minimum of preparation time and expense to obtain or reproduce materials or ideas recommended.

Designed as part of the regular ongoing types of school activities and programs.

Includes suggested behavioral objectives, learning experiences and assessment methods in convenient format.

Easily updated, due to its loose-leaf format, via replacement of pages upon their obsolescence.

In developing this manual, certain assumptions were made by the project participants. Cognizance of these basic suggestions is a must in effective use of the project's end-product. The assumptions are that each district:

1. Has or will have already implemented a comprehensive health education program for its students K-12, the drug education portion of which directly relates to student knowledge, attitudes and behaviors and is purposely not repeated in this manual.
2. Believes that prevention is more efficacious and cost effective than treatment. Diverting youth from socially and personally destructive behavior, rather than mopping up the casualities, is the ultimate goal.
3. Feels responsible to help provide alternative ideas, pursuits, and programs for students and their parents.
4. Has the resources for utilizing the guidelines contained within the manual for conducting special training for faculty, parents and students.
5. Understands that the careful selection and use of suggested resources can be a key to effective and interesting programming.
6. Will use the assessment tools for gauging the knowledge, attitudes and behaviors of various groups for its own personal program evaluation rather than for comparing the extent of one district's problem to that of another within the County.
7. Will encourage those who use this manual to acquaint themselves fully with its contents and with the basic language of substance abuse.
8. Realizes that planned change has the highest probability of being effective change and that coordination between the school and community is essential when considering change.

However, whatever the organizational plan to use this manual, the only significant test of its worthwhileness is the effect which it brings to bear on the total education program or the opportunity which it affords children to learn and become all that they are capable of being.

INTRODUCTION

According to The School Team Approach, from the U.S. Department of Education the following individual behaviors and attitudes may serve both as goals and possible evidence, when they occur, of effective prevention or early intervention programming:

1. Decrease of alcohol and drug abuse in the school.
2. Increased positive self-worth.
3. Development of a sense of accomplishment.
4. Improvement/development of skills for relating to peers.
5. Improvement/development of attitudes and skills for relating to adults.
6. Development of a sense of influence over one's own life.
7. Development of a workable value system.
8. Improvement/development of skills in decision-making.
9. Awareness of reality and its consequences.
10. Reduced truancy.
11. Reduced discipline problems.
12. Improved grades.
13. Reduced dropouts.
14. Increased interest in long-term educational goals.
15. Improved social services that relate to the needs of the individual.
16. Less overlap and conflict among social service agencies.
17. A better working relationship among schools and other agencies.
18. A redefinition of the drug problem so that the complex nature of personal and social causes is translated into appropriate responses; i.e., drug laws more in balance with the offenses.
19. More schools and families working closer together; i.e., communication workshops which involve parents, students and teachers.

Districts may wish to use any or all of these, intact or as amended, to serve as their own long-range goals. Written in specific quantifiable and measurable terms, specific objectives may be easily derived at the appropriate phase of the district's programming.

Most of what we teach a child today will be obsolete by the time the child goes to use it. Therefore, we need to teach the skills of how to replace this information. According to Dr. Steve Glenn, what causes people to become dependent is our lack of ability to develop capable individuals who can take charge of their lives. We need the courage to do what we know we need to do:

1. Provide more viable role models - so we can model and teach what we believe in.

2. Take more personal responsibility for what happens.

3. Believe we can make an impact by recognizing, understanding and applying certain principles of discipline, judgment and responsibility.

A firm, fair and consistent system for running a school seems to be a key factor in reducing violence, a sign of substance involvement by young people. When rules are known, and where they are firmly and fairly enforced, less violence occurs. Good coordination between the faculty and administration also promotes a better school atmosphere. (The Safe School Study Report to the Congress-Dec. 1977).

With these thoughts in mind, it becomes easy to understand that school personnel do not need to become "experts" on drugs in order to be effective in drug abuse prevention. Helping young people to understand and say "no" to pressure from their peers in ways that they won't feel they will lose their "cool" in front of their friends is an important function of the school - the place where the child spends up to 1/3 of his/her day. The school is also in a fine position to use peer group pressure (one of the most influential elements in adolescent development) to its greatest advantage.

Similarly, the school is in a strategic position for taking the resources the person has at the present time and turning them into operational forces - for using the natural pain the individual experiences during maturation as a source of growth. Finally, the school has the ability to offer alternatives to the path to substance abuse. However, in offering such alternatives, something equal to or better than what they have must be offered since no one goes, by choice, from comfort to pain.

It is to encourage such noble undertakings that this manual was designed.

HISTORICAL PERSPECTIVE

Effects of Rapid Societal Change on Today's Adolescents

In the United States until about 1935, 70% of the population lived a basically rural life style in which the child began working along side one or both parents at an early age. There was a high rate of involvement and interaction then with parents, so that at 12 or 13, if one parent was absent, the oldest could usually step in and fill that role fairly well. By 16 or 17, there were few mysteries about being an adult because he/she had received on-the-job training an average of 12 hours a day. Children are participants and not just observers in the adult world.

At that time, attitudes, values and behaviors of each generation were passed on quite well to the next generation as the natural result of interaction between parents and children within the family unit. Living in an extended family had important consequences. One had aunts, uncles, and grandparents close at hand. In the environment of that period, there was what now would be termed a great surplus of significant interaction within the family. A child born in the home and growing up there tended to be like his parents. On the other hand, because of isolation, the rural population had very limited access to extensive information or knowledge about the world.

Schools were developed by parents with the task of giving kids an experience in sitting quietly for an hour or so a day learning discipline and some information. Children of all ages met together to be taught reading, writing and arithmetic by a teacher carefully selected by several parents. Quite naturally, parents selected a teacher whose values and behavior reflected their own.

Between 1900 and 1950, the most massive social change in history took place. By 1950, 70% of all Americans lived in an urban environment and only 30% on farms, almost a complete reversal had taken place. The trend in urbanization virtually eliminated the likelihood that a child would work for any significant part of his time alongside either of his/her parents. When a child ran out of the house he ran into a variety of different behaviors, different value systems and different lifestyles than he was seeing at home.

By 1970, over 90% of all Americans lived in an essentially urban lifestyle. An inevitable result was longer and longer school hours. Interaction with family decreased and interaction with peers increased. Teachers no longer reflected the values and attitudes of the parents.

Coupled with the rapid transition to social change was the abvent of rapid technological innovation. The introduction of television in 1948 eliminated the effects of time, space, geography, distance, culture, role models and value systems from the previous effects of the family. In addition, it significantly reduced family interaction time. Over the last 35 years, we have moved a high interaction-low information society to a low interaction-high information society.

At birth, a child has no skills for living. Initially, s/he has no learned behavior. By age 18, society expects him to have acquired the necessary independence, self-reliance and socially responsible attitudes, values and behaviors for every conceivable adult situation which s/he may confront. Basically all we ask is the his/her home and school combine to take a totally dependent child and turn him/her at 18 into a totally responsible adult. Considering the major transitions in life style and their implications over the past 35 years, this is no easy task. These conditions have contributed to an increasing number of youth finding it difficult to identify the resources necessary to develop the capacities for coping and functioning acceptably in our modern society.

Transitions of America's families from 1930 to 1978 is summarized in the chart on the following page.

Reference: H. Stephen Glenn "The Prevention of Alcohol and Drug Problems: A Commentary." Common Ground: Pennsylvania Prevention Forum, Issue #1, February 1979

TRANSITIONS OF AMERICA'S FAMILIES 1930 TO 1978

1930	←→ 1978
AGRICULTURE (75% on farms) (In colonial times-91%)	INDUSTRY (75% in urban areas and 90% with urban lifestyles)
LITTLE ANONYMITY (Everyone knew you)	GENERAL ANONYMITY (Rarely do you know someone a few miles from your home)
WORK CENTERED ON OR NEAR HOME (Kids saw process of decisions being made)	WORK AWAY (Kids don't understand the pressures and decisions being made)
MUCH FAMILY WORK	LITTLE FAMILY WORK
LARGE FAMILIES	SMALL FAMILIES
EXTENDED FAMILIES	NUCLEAR FAMILIES
FEW BROKEN HOMES	MANY BROKEN HOMES
FEW LIFE CHOICES	MANY LIFE CHOICES
LIMITED INFORMATION	VAST AMOUNTS OF INFORMATION
MEDIA INSIGNIFICANT	MEDIA INFLUENTIAL
TIME VALUED	INSTANT GRATIFICATION
FEW DRUGS	MANY DRUGS
FEW HOURS OF SCHOOL (With same teachers and small size class)	MANY HOURS OF SCHOOL (With different teachers and different, large groups of kids)
BELIEVABLE ROLE MODELS	DISONANT ROLE MODELS
LITTLE PEER GROUP EMPHASIS	HEAVY PEER GROUP EMPHASIS (really self-pressure)
EIGHT HOURS OF MEANINGFUL INTERACTION WITH FAMILY MEMEBERS	FIFTEEN MINUTES PER DAY OF MEANINGFUL INTERACTION BETWEEN HUSBAND AND WIFE. (14 min. in 1980) TWELVE MINUTES BETWEEN PARENT AND CHILD (10 min. spent in telling child what to do)

ABOVE INFORMATION IS FROM STEPHEN GLENN'S STUDY ON THE AMERICAN FAMILY PUBLISHED IN 1978.

TRENDS

The increasing difficulty children have in growing up to become healthy responsible adults is best demonstrated by current trends over the past fifteen years. The following information speaks strongly of the degree of developmental distress prevalent among adolescents:

- Increases in juvenile delinquency, ranging up to 300% in some areas.

- Suicide becoming the second leading cause of death among teenagers (accidents ranking first) and the leading cause of death among college students.

- Young women gave birth to 660,000 children out of wedlock during the year ending in May 1977, up from 330,000 from the previous year.

- Incidence of violent crimes for the 12-18 age range was increased by 273% over a one-year period.

- 1.4 million of the 4.32 million 19 year olds in America last year had already broken the law or were well on their way toward obtaining a criminal record.

In the area of substance use and abuse we are faced with the following data:

- Alcohol dependency problems have increased by 600-800% for the 12-21 age range. It ranks as the second leading health problem in this age group next to VD and as the number one problem in the 18-21 age group.

- Over half of our students will have tried an illegal drug by the time they graduate.

- The drugs used most often by high school seniors on a daily basis are: tobacco (29%), marijuana (9%), and alcohol (6%) according to the National Institute on Drug Abuse.

- Studies have shown that more than 70% of teenagers have tried alcohol; and by the time they reach their senior year, almost 93% have done so.

Steve Glenn, Director of Program Services for American Health Services, Inc. has noted that "...one-third of all teenagers who reached the age of 18 last year were overtly dysfunctional in significant areas of their lives and were grappling unsuccessfully with problems of family discord, drug abuse, alcoholism, sexual orientation, hard-core unemployment, equally frustrating under-employment and law-breaking."[1]

TRENDS - (Cont.)

In terms of impact on our society, Glenn indicates, "... if the present trends continue by 1980, we will reach the point of every productive wage earner picking up the cost of one-half of a dysfunctional individual. This means that one-third of the population (including juveniles between 12 and 18), will be making demands on the American criminal justice and human service systems." 2

Footnotes:

1. Steve Glenn; Underlying Generators of Crime Identified by Child Care Experts

2. Corruption Digest, December 9, 1978

YOUTH, ISOLATION AND MORAL DEVELOPMENT

Lawrence Kohlberg has developed a theory of moral development which is relevant to our concerns about the increasing isolation of young people. In his theory, Kohlberg suggests (as do theologians, such as Paul Tillich), that the foundation, on which our moral development is based, is the "distinctively human structuring of action and thought by role taking, by the tendency to react to others as like the self and to react to the self's behavior from the other's point of view." In this way, we develop a kind of emphatic experience with others, and, through this emphathy, we gradually learn to resolve conflicts that arise with one another in a just manner, using equality and reciprocity. In this way we develop our moral sense. This kind of emphathic learning can only be acquired through our involvement with one another, and it demands time and attention.

If, as Kohlberg suggests, role-taking involvement is the foundation of our moral sense, it is extremely important to our development. Let us examine how available these role-taking opportunities are to young people in our culture.

FAMILY

If we analyze the role-taking opportunities in the family, we commonly see father as absent from the family by reason of divorce or absent frequently as a result of job demands in a highly competitive society. The mother is filling the roles of housewife, mother, wife, full or part-time father and, possibly, wage earner. This leaves the children with little opportunity for role-taking with either parent. For many kids, important parental surrogates, like aunts, uncles, older cousins and grandparents, are either a freeway ride away or living in other states and not accessible for relationships.

SCHOOLS

Teachers and fellow students could provide opportunities for role-taking. However, the trend in recent years has been to create larger schools for younger and younger children, and to change teachers and classmates with each subject. These trends were designed to increase the efficiency of education. Unfortunately, they diminish opportunities for role-taking. Many teachers teach as many as 150 different students in one day. Under these conditions, there cannot be sufficient time and energy for the person-to-person contact that makes role-taking possible.

PEERS

Peers have always been a readily available group for role-taking. With the current large population of adolescents and the relative inaccessibility of adults, the best friend, now, is more likely to be a group of peers. When we associate in groups rather than one-to-one relationships, role-taking becomes more problematic. It takes longer to develop empathy in a group. We are less likely to work out equal or reciprocating solutions to conflict and more likely to rely on group pressure and majority rule to resolve conflict. For better or for worse, peers now seem to be the major source of role-taking opportunities for many young people.

NEIGHBORS

Neighbors are a diminishing role-taking resource for our young people. We move often, and, for the most part, believe in taking care of ourselves and not "bothering our neighbors". And, our young people pick up that message. We often feel responsible only for our own children.

Of course, the neightbors are as busy as we are. They do not have the time and leisure necessary for genuine role-taking and empathy. In our culture, time and liesure are at a premium. First, our work demands a great amount of our time and emotional energy. Second, we have so many distractions . . . television, movies, restaurants, shopping. These are much less emotionally demanding than interacting with one another.

ROLE-TAKING AND TELEVISION

Aside from the time which television viewing takes away from personal involvement with one another, it is interesting to speculate about its effect on role-taking. Television has an abundance of characters we see as "like ourselves" (as well as heroes and heroines whom we want to be like). However, with a television character we have no opportunity to work out our conflicts, to establish just, reciprocal relationships with one another. The danger in television is that it enables us to feel less alone without allowing us to learn how to resolve conflicts with one another. The danger in television is that it enables us to feel less alone without allowing us to learn how to resolve conflicts with one another. The simplicity of the relationship between the viewer and the television character can only make the struggle in relating to real people seem more risky and complicated.

This cursory examination of role-taking opportunities in urban culture suggest that concern about young people's isolation is well founded. If, Kohlberg's theory of moral development[1] is valid, this isolation and loss of role-taking opportunities could seriously impair the development of our young people.

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[1] Excerpted from Cognitive Development and Epistemology, Mischel, Theodore (editor). From the chapter "Is To Ought" by Kohlberg.

DAZZLE THEM WITH BRILLIANCE

OR

BEFUDDLE THEM WITH FACTS

At some point in your school's crusade to minimize substance abuse, you may find the data on the following fact sheets useful to win a debate, impress your supporters, or befuddle your opponents!

One out of every 2 couples married gets divorced.

38% of our homes can be classified as broken.

Only about 1/3 of America's families currently consist of children living with both natural parents in one household. (Kinzer, 1978)

Average time a father spends with his son is 37 seconds per day. (Boston Study)

By the time a child is 18 years old, s/he has viewed 18,000 murders and 380,000 commercials on TV. S/He has watched 18,000-22,000 hours of TV, spent 12,000-15,000 hours in school and 3,000-4,000 hours with parents.

One out of every 6 commercials on prime time television advertises some form of drug or chemical. (Schaps, 1976)

More money is spent nationally on vandalism than on textbooks - enough to hire an additional 50,000 teachers.

1/2 the crime in Cortland County is drug related. (Trooper Phillips, 1981)

30% of all deaths today in America are premature due to alcohol and tobacco use. (Dr. Robert DuPont, 1981)

Drug abuse almost always occurs in the context of other social and emotional problems.

80% of deaths in America today are due to lifestyles.:(Gaetano, 1981)

6 of the leading killers in the U.S. are related to lifestyle : (Silverstein, 1981)

$48 billion/year - costs of alcohol abuse to American public.

$10.3 billion/year - costs of drug abuse to American public.

$25-$30 billion/year - costs of smoking to American public.

500,000 - heroin addicts at its peak in 1960's.

12,000,000 - alcoholics today in U.S.

Kids, women and elderly get addicted to alcohol more rapidly.

It takes 10 years to change the system. You better start now!

Psychological development/maturation stops when addiction crosses the lifeline; so there is no "pre" personality to refer to in young people's rehabilitation.

1 out of 4 kids in each classroom is affected by someone's drinking at home.

Children tend to curcify the non-addicted parent feeling the latter drove the addicted parent to drink.

1 out of 10 beginning drinkers will develop alcoholism.

7% of the total U.S. population are daily drinkers consuming over 50% of the beverage alcohol.

2/3's of the adult population drinks.

About 1/2 of all alcoholic beverages are consumed by only 11% of those 18 and older.

1961 - 1% of 12-17 year olds used marijuana.

1979 - 33% of 12-17 year olds used marijuana.

1981 - there are over 4 million regular 12-17 year old pot smokers.

1978 - 64% of all high school seniors have tried drugs at some time in their lifetime.

Over 1/3 of high school seniors smoked marijuana in the last month.

Over 10% of high school seniors smoke marijuana daily - almost twice the percentage who drink alcohol daily - consuming an average of 3½ joints every day of their senior year.

Over 1/3 of high school seniors reported using drugs other than marijuana at some time.

69% of the nation's young adults (18-25 years) have tried marijuana compared to 4% in 1962. (1980 National Institute of Drug Abuse)

Of the total current users of marijuana, 2/3's of 15 million Americans, report taking it 5 or more times per month.

In study at Masters and Johnson Institute, 40% of women using marijuana either did not evaluate or had abnormal menstrual cycles.

Largest category at college is the "undecided" major. (Kids can't make decisions and choices).

Teachers teach the whole person. Instructors pass on information to part of a person.

People generally remember:

- 10% of what they read
- 20% of what they hear
- 30% of what they see
- 50% of what they see and hear
- 70% of what they say and write
- 90% of what they say as they do a thing

AMMUNITION ON ALCOHOL

Alcohol is associated with:

2-3 times the respiratory illness of the average person.
2-3 times the heart disease of the average person.
80% of cancer of the larynx.
50% of the first admissions to state mental institutions (mostly misdiagnosed as something else.)
Development of secondary female characteristics in the male.
60% of the impotence due to direct nerve damage.
Shatter fractures due to bone weight changes.
Impairment of clotting factor - occasionally to the point of hemorrhage.
Impairment of the activity of antibiotics, insulin and epilepsy medication.
Decreased immune response.
50% of the mental and physical handicaps in offspring (disease such as fetal alcohol syndrome).
80-85% of death row clients in 3 southern states had alcohol problems.
40% of the admissions to hospitals relate to alcoholism.
40% of the crime evidenced by daily arrests in county prisons.
50% of the deaths from falling.
50-68% of the drownings.
50% of the traffic accidents.
50% of the cases of incest.
50% of the cases of homicide
50% of the cases of child abuse.
50% of the cases of wife abuse.
50% of the adult deaths from fires
10 times more use of health insurance.
3 times per year more use of social services.
12 million alcoholics who live 10 years less than they would normally have been expected to live.
1 out of 10 kids 10 years old and over is alcoholic.
The alcoholic negatively affects a minimum of 3 other persons.
12 x 3 = 36 million person problem.
50% of alcoholics have an alcoholic somewhere in their family tree.
Only 1 out of 36 gets identified and treated (Other 35 die untreated).
Alcoholism is a disease which is treatable (not curable) and the earlier the better.
Tolerance increase or decrease, an irreversible process, is a symptom of alcoholism.
Alcoholics typically have higher IQ's.

ROLES AND RESPONSIBILITIES
OF
SCHOOL PERSONNEL

ROLES AND RESPONSIBILITIES OF SCHOOL PERSONNEL

Section Content

Preparing to Respond to Drug Situations
Chemical Dependence Program Pitfalls
One School's Approach
Review of the Basics of Preventive Education
Basic Considerations for K-12 Curriculum
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Signs for Use of Substance for Drugging Effects
Teacher's Role
Receptivity To Learning
Five Principles of Intervention
The Responsibilities of a Host
Composition of Some Alcoholic Beverages
Blood Alcohol Level, Body Weight vs. Number of Drinks Consumed
How To Keep The Life of The Party Alive
Methods to Control Drinking Patterns
Personal Plan of Action For Non-Smokers
Both Administrators and Teachers Responsibilities
Definite Differences Between the Terms Discipline and Punishment
Activities - Positive Behavioral Techniques to be Used by Various Teachers:

    Art
    Physical Education
    Health
    Social Studies
    Language Arts
    Science
    Math

Guidelines For Parents or Answering Questions About Drugs
Relfections By a Homer Parent

Preparing To Respond To Drug Situations

School administrators and staff are being confronted more frequently with instances of student drug use. The ability of school personnel to effectively respond to these situations is impaired by several factors:

1. Vague or conflicting laws and legal interpretations.
2. Ambiguity over the rights and responsibilities of students, staff and parents.
3. A pervasive feeling that little can be done to handle or prevent drug and alcohol problems.

It is important that school officials review their current methods of responding to student drug involvement. During this review, administrators should be concerned that school policies are legally sound, school staff are properly prepared and that preventive education programs are underway.

Important Considerations

If any response to drug or alcohol use is to be effective, it must be reasonable and positive in its intent. There are some basic ideas to be considered by any school administration before it is forced to act in a drug or alcohol situation.

1. Drug use and abuse occurs within every school population. Much of this use may be unseen during the school day. However, it persists. Instances of student use during the school day are becoming more numerous.

2. There are positive steps that can be taken to prevent, intervene and reduce the abuse of chemical substances. These steps can be effective in helping the student and protect the school population at the same time.

3. When disciplining students, you are dealing with a complex being going through periods of tremendous change and growth. Most students do not behave or react as an adult in a consistent manner. It is simplistic to use the rule of discipline. "The student knew the consequences and deserves any punishment he or she gets." This too often ignores other crucial factors.

4. Discipline should mean more than just punishment. This word implies a concern for the total mental and moral development of the individual student.

5. Extreme punishment may succeed in submerging current drug usage. This makes it very difficult to identify and intervene in the abuse of a student. Expulsions have the potential of intensifying the drug use of the student involved.

Important Considerations (Cont.)

6. All members of the school population have rights, rules, and responsibilities within the school's system. This is equally true in terms of drug use and abuse. It is important that these factors are clear to all involved and considered in all drug related situations.

7. There is a complex relationship between the role of the school in its care of a child and the laws that relate to that care.

The First Step, The Committee

The major recommendation we put forth to all school districts is to undertake an indepth review of current drug and alcohol policies and instructional activities being utilized in your school or district.

It is preferred that the review process be completed by a committee representing a cross section of the school community. Important individuals to be considered for this committee include: school administrators, teachers, students, school nurses, school counselors, parents, drug and alcohol professionals, doctors, ministers and other interested volunteers.

If the committee process cannot be utilized, every effort should be made to complete an objective review of school policies and procedures.

(For further help in dealing with the policy issue, see the section of this manual on Legality and Policy).

CHEMICAL DEPENDENCY PROGRAM PITFALLS

Programs in the drug area often fail for these main reasons:

Too narrow or too broad a scope or content of program.

Setting or selecting and working a scapegoat issue like getting rid of paraphernalia, or busting drive-throughs, etc.

Using scare tactics or propaganda: neither work, both tend to be counterproductive.

Create programming only for the "problem" kid and neglect the majority who need prevention and educational programming.

Neglecting to focus on our own attitudes and values, particularly about chemical use. This includes all those areas of lack of information about our own use-misuse-abuse which may tend to turn us off about others.

Dealing with the issue of chemical dependency as only a discipline problem. It is more, a social and medical problem.

Any "turf issue" of "I know all about that already because I am a... " or "that is my job to notice, stay out of it", etc.

Fear. This whole issue is scary and can paralyze almost all of us at times. Knowing what to do, in what order and to report to who, etc. is very helpful and allows fear to be less paralyzing.

Outside consultants and other experts can most effectively block programming as the school waits for them to inform the school what they should do next. In short, the school does not really own the program. The consultant does. Not good.

Lack of clear and effective policies and procedures. This can block everyone at every level of programming. This policy is a public statement of support and concern. It is vital!

Every block is us in some way. Anything we do which is aimed at us rather than the program can be destructive.

When our program aimed at prevention of substance abuse is being established or adjusted, certain guidelines or basic principles, if adhered to, will help to insure its success. These are as follows:

1. Develop it gradually rather than superimposing it abruptly.
2. Though idealistic in its announced goals, it is realistic in its current performance.
3. It fosters continuous communication between all school staff members.
4. Special facilities are at its disposal.
5. It is interwoven with the instructional program.
6. It brings its services to every student, parent and staff member not just to those in distress.
7. It plays an important role in the school's public relations program.
8. It is constantly engaged in a process of self-examination.
9. It insures a balance in services it offers pupils.

Once the program is ready to be established or adjusted, there are certain general fundamentals which should be considered in its administration:

1. There should be centralized control to assure efficient and effective functioning of the total program.
2. Adequate budgeting of finances to provide necessary salaries, supplies, and equipment should be carried out.
3. There needs to be proper coordination of various divisions, departments, and areas.
4. Selection of teachers and health specialists should be based on the best qualifications for the particular school and community.
5. Allotment of sufficient time in the school curriculum for the program to function effectively is a necessity.
6. Definite assignment of duties and responsibilities to teachers, health specialists, and administrative assistants is a must.
7. Organization of the teaching program should be on a school-wide basis.
8. Consideration of legal provisions, state and local laws, and requirements pertaining to and affecting the program should not be neglected.
9. Methods and plans for dealing with staff, as well as students and their parents, should be an integral part of the plan.
10. There should be constant and thorough evaluation of the total program.

ONE SCHOOL'S APPROACH

General Steps to Building a Program

1. What's the need.
2. Gather information regarding your strengths and weaknesses; specific needs of your setting.
3. Determine what is feasible.
4. Identify a core group of people who can help.
5. Design an outline for ways to meet your needs through programming.
6. Broaden your support base, if possible.
7. Evaluate what you have done; review original ideas; look for strengths and try to anticipate problems in people and program in the months ahead.
8. Continue to learn, grow, train yourself.
9. Continue to refine, reevaluate, innovate.

Some Specific Steps In Starting A Program

1. Getting "in charge" persons to recognize that there is a problem with drugs, alcohol, and a lack of emphasis on general life coping skills.
2. Form a committee of concerned administration, parents, and teachers to search for possible approacnes to this problem.
3. Try to establish a realistic long range goal.
4. Establish the need for an ongoing program - not one shot, short range projects.
5. Present ideas about approaches at a meeting of the leaders for parents, administration, and faculty.
6. Pursue various approaches.
7. Develop a plan of attack.
8. Gather support by speaking with interested faculty, parents, and new administrators.
9. Prepare a letter (non-threatening, awareness raising) to be sent before opening day to the general faculty which introduces the idea of the Human Resources Program (or whatever you are beginning).
10. On the opening day of school deliver a twenty minute presentation to the faculty about the need for program, what was coming up, and their expected role in it.
11. Bring in speakers; develop courses for parents and faculty; train faculty.
12. Ongoing parent meetings.
13. Implementation of Project Sunshine (or other program).
14. Ongoing refinement of program.

REVIEW OF THE BASICS OF PREVENTIVE EDUCATION

Alcohol and Drug education principles are based on the premises that:

1. a primary responsibility of the school is to provide students with learning experiences and skills which will enable them to function successfully in a rapidly changing society without the use or abuse of alcohol or other drugs.
2. alcohol and drug abuse are serious social problems to which the school,as a primary influence in the socialization of children, must respond.
3. the response should be manifested in a carefully planned, well coordinated K-12 alcohol and drug education curriculum, the focus of such curriculum being the development of mentally, physically and socially healthy young people.
4. the most effective alcohol and drug education program is a synthesis of content (cognitive) and behavioral (affective) approaches adjusted to the needs and concerns of the students and community.
5. students, school personnel, parents and community resources should be involved in the planning, implementation and evaluation of the program.

Just as each school must analyze its own approach to intervention and discipline, it must also review the type and amount of prevention activity that occurs within its classrooms.

BASIC CONSIDERATIONS FOR K-12 CURRICULUM

Grades K-3

Purpose: Promote and Maintain Good Physical and Mental Health

Recommended Goals: Children should be taught respect for medicines and other potentially dangerous drugs.

Children need to know about common medicines and how they are used.

Children should learn that drugs used under a doctor's prescription for a definite illness are proper and beneficial.

The concept that unknown substances might produce psychological harm should be developed including another person's medicine or pills or substances offered by friends or found somewhere.

The primary developmental task during this period is learning to deal with others socially and cooperatively. The teacher should help students develop understandings of why people do what they do, how to set personal goals, and why respect for rules and laws is important.

Recommended Goals: (Cont.)

Children should learn constructive alternatives for handling anger, fear, frustration, anxiety, loneliness, jealousy and prejudice.

Children can begin to understand problem solving and decision making as a dynamic process.

Children should learn what they do does affect others and is of concern to others.

Children should learn that there is always more than one choice available, that each choice has its advantages/disadvantages in terms of positive or negative consequences. Each child should know that s/he must be ready to accept the consequences when s/he has made a decision.

Grades 4-6

Purpose: Students Recognition That They Are Responsible For Their Own Behavior and Decisions

Recommended Goals:

Students' awareness of their increased responsibility for their own behavior and for the decision governing their personal alcohol and drug use that they will make in the near future.

Students need to learn the various non-medical rules substances (alcohol and drugs) have in our society.

Concepts presented in earlier grades about mental health and life coping processes should be further developed (these concepts include how emotions affect behavior, the interactions between feelings and thought processes, the relationship between emotions and body, and the effects of self-image on reactions to criticism, praise or prejudice).

The topics of problem solving, decision making, understanding, behavior, expressing feelings honestly and constructively, active listening, and group belonging and acceptance should be developed.

Students will need to learn skills for successfully dealing with disapproval and rejections from significant others.

Motives for using and not using drugs should be discussed. Children need to become familiar with the concepts of drug/alcohol dependence, drug/alcohol abuse, and the prevention of substance abuse.

Grades 7-9

Purpose: Students' Development of Self-Understanding and Effective Life Coping Skills

Recommended Goals: The concept that human behavior is a response to meeting one's emotional, social, intellectual, moral or physical needs should be developed.

The roles of family, peers, and social institutions in influencing the individual's behavior and values should be explored. The personal and social controls on alcohol and drug use should be discussed within this behavioral context.

Junior high students are becoming aware of the complex nature of an individual's behavior. They should recognize how emotional conflicts, unsatisified needs and unrealistic expectations of self and others can cause developmental problems.

Students should be presented with factual information about durgs and alcohol. The information should include discussions of known affects (good and bad). Students should know the various psychological, social and environmental factors that might modify the affects of a given dose of alcohol and drugs.

Students should become informed consumers of prescription and non-prescription drugs.

Students understandinq of social development should include the respect of the rights and feelings of others, being dependable and reliable and assuming the responsibility of one's behavior. The ability to think and to make decisions as a member of a group is part of social development. How one's self-concept and values affect behavior in groups should be discussed. Peer pressure to use alcohol and drugs should be related to these aspects of social development.

Grades 10-12

Purpose: Students' Understanding That Alcohol and Drug Abuse Are Social Issues Toward Which They as Young Adults Must Respond

Recommended Goals: High school students should deal with the concept of multiple determinants of alcohol and drug abuse.

Recommended Goals: (Cont.)

Students should discuss how their values affect their personal behaviors and styles of decision making as problem solving. Adolescents can understand some of the long-range consequences of the decisions they make.

Students are aware of their developing life styles. Their decisions related to personal use or non-use of alcohol and drugs should be examined in relationship to one's choice of life style. Students should consider how a life style which includes alcohol and drug use might infringe on the rights and welfare of others.

Adolescents can discuss the role of parents in preventing alcohol and drug abuse among family members. Parenting skills, including family problem solving and communications should be a topic discussed with students.

Students are interested in alternative ways of meeting their needs and solving personal problems without using alcohol and drugs. Students need to see that these options exist.

Factual information about drugs and alcohol presented in the earlier years should be further developed. Students should be informed of the effects and interactions of drugs (perscription and non-prescription) and alcohol on their physical and mental condition.

REFERENCE:

Alcohol and Other Drugs: (K-12 Curriculum)
State of Iowa
Department of Public Instruction
Grimes State Office Building
Des Moines, Iowa 50319

FACTORS RELATED TO DRUG AND ALCOHOL ABUSE, RUNNING AWAY, PREMARITAL INTERCOURSE, DROPPING OUT OF SCHOOL, MENTAL HEALTH PROBLEMS, AND ADOLESCENT PREGNANCY*

FACTORS	Drug and alcohol abuse	Running away	Premarital intercourse	Dropping out of school	Mental health problems	Adolescent pregnancy
PHYSICAL/GENETIC						
Failure to meet basic survival needs, health care, nutrition, housing, and employment					X	
Early Physical maturity for girls						X
Early physical maturity for boys			X			
Inherited toxic reaction	X					
Cardiovascular injury	X					
Dimished thinking and body reaction	X					
COGNITIVE/EMOTIONAL						
Low psychological well being	X					
Low self-esteem	X	X	X	X		
Insecurity, shyness, feelings of inadequacy	X					
Alienation and lack of meaning	X					
Lack of long-term goals					X	
Low ego maturity					X	
Rebelliousness	X					
Impulsiveness	X		X		X	

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*Delivered at "Schools, Youth, and Substance Abuse: An Institute on Problems and Solutions for Educators", June 29-July 1, 1981, Wyoming Seminary.

FACTORS	Drug and alcohol abuse	Running away	Premarital intercourse	Dropping out of school	Mental health problems	Adolescent pregnancy
COGNITIVE/EMOTIONAL (cont)						
Irresponsiblity	X					
Higher stress level	X				X	
Lower academic aspirations	X			X		X
Negative attitude toward school	X	X		X		X
Low cognitive development	X		X			
Inconsistency between youths' and parents' opinions about drugs	X					
Tolerance of defiance	X					
Positive value toward drugs	X					
Sensation-seeking tendencies	X		X			
Low religiousity	X		X			
BEHAVIORAL						
Low school grades	X			X		
Low school achievement	X			X		
Disciplinary problems in school	X	X		X		
Frequent school absences	X			X		
Lack of participation in school activities	X			X		
Impulsiveness	X					
Agressiveness	X					
All types of antisocial behavior	X	X		X	X	X
Frequent use of cigarettes, alcohol. and other drugs	X	X	X	X		
Delinquent behavior	X	X	X			

FACTORS	Drug and alcohol abuse	Running Away	Premarital intercourse	Dropping out of school	Mental health problems	Adolescent pregnancy
SOCIAL NETWORK (Family)						
One or both parents missing	X		X	X		
Death of family member				X		
Broken home				X		
Divorce of parents				X		
Lack of closeness between parent and child	X					
Low support and affection by parents	X					
Poor parent/child relationship		X				
Poor communication				X		
Rejecting parents		X				
Incest				X		
Low control and supervision by parents		X	X			
Lack of consistent discipline			X			
Parents overprotect or overcontrol		X				
Parents have low involvement with child		X	X			
Stressful family conditions				X		
Stressful home situation				X		
Father unemployed	X					
Mentally ill parents	X					
Parental drug use	X					
Alcoholic parents	X					

FACTORS	Drug and alcohol abuse	Running away	Premarital intercourse	Dropping out of school	Mental health problems	Adolescent pregnancy
SOCIAL NETWORK (Peers)						
High peer drug use	X					
Friends modeling problem behavior	X					
Approval of and model for problem behavior	X	X	X	X		X
High peer-group involvement	X	X				
High need for peer approval	X					
Isolation from peers		X				
Death of friend				X		
SOCIAL NETWORK (Socioeconomic Status)						
Urban, inner city resident			X			
Poverty, low income				X		X
Low educational attainment of parents				X		
SOCIAL NETWORK (Religion)						
Low Church attendance	X		X			
SOCIETAL/CULTURAL						
Broader society is a "drug" culture	X					
Equal rights for women			X			X
Decrease in early marriage						X
Media portrayal of drugs as glamorous	X					
Spread of new drugs has a "fad" quality	X					

GOLDEN RULE FOR RELATIONSHIPS

You may have seen this before. It comes from Dr. Thomas Gordon, in a book called PARENT EFFECTIVENESS TRAINING. Dr. Gordon lays down a formal credo for getting along. Sometimes rules help; it isn't always easy living up to expectations (yours or somebody else's). This is the way Dr. Gordon frames it, and maybe it makes sense for your situation. Imagine what a glorious place this world would be if we all agreed to live by this Golden Rule For Relationships.

> You and I are in a relationship that I value and want to keep. Yet each of us is a separate person with his own unique needs and the right to try to meet those needs. I will try to be genuinely accepting of your behavior when you are trying to meet your needs or when you are having problems meeting your needs.
>
> When you share your problems, I will try to listen acceptingly and understandingly in a way that will facilitate your finding your own solutions other than depending upon mine. When you have a problem because my behavior is interfering with your meeting your needs, I encourage you to tell me openly and honestly how you are feeling. At those times, I will listen and then try to modify my behavior, if I can.
>
> However, when your behavior interferes with my meeting my own needs, thus causing me to feel unaccepting of you, I will share my problem with you and tell you as openly and honestly as I can exactly how I am feeling, trusting that you respect my needs enough to listen and then try to modify your behavior.
>
> At those times when either of us cannot modify his behavior to meet the needs of the other and find that we have a conflict of needs in our relationship, let us commit ourselves to resolve each such conflict without ever resorting to the use of either my power or yours to win at the expense of the other losing. I respect your needs, but I also respect my own.
>
> Consequently, let us strive always to search for solutions to our inevitable conflicts that will be acceptable to both of us, in this way, your needs will be met, but so will mine - no one will lose, both will win.

8

SURVEY QUESTIONS

Does you school...

1. Have social or ethnic problems? Yes ___ No ___
2. Have a high truancy rate? Yes ___ No ___
3. Have cases of vandalism? Violence? Serious fights? Gangs? Drug problems? Yes ___ No ___
4. Have many cases of student arrests? Yes ___ No ___
   (If you don't know the answers to all the above, local law enforcement agencies may be able to give you some information.)
5. Plan events which encourage school unity? Yes ___ No ___
6. Have good recreational and extra-curricular activities which are well supported by the student body and staff? Yes ___ No ___
7. Provide good counseling and health services? Yes ___ No ___
8. Give everyone the opportunity to respect their own heritage and those of others? Yes ___ No ___
9. Involve parents in important school decisions and events? Yes ___ No ___
10. Seek a constructive bond with the community/urban or neighborhood improvement projects, law enforcement, the handicapped, the elderly, etc? Yes ___ No ___
11. Use community agencies or the expertise of residents to help with school programs? Yes ___ No ___
12. Direct students and parents to community resources which will improve their lives? Yes ___ No ___
13. Provide students with real leadership opportunities (not simply token positions)? Yes ___ No ___
14. Have an "emotional climate" in which the students, faculty, and administrators feel free to express their thoughts and feelings? Yes ___ No ___
15. Encourage students to be creative and curious? Yes ___ No ___
16. Help students explore and appreciate their own special talents? Yes ___ No ___
17. Allow students to clarify values? Yes ___ No ___
18. Provide problem-solving and decision-making experiences for students? Yes ___ No ___
19. Help students to effectively deal with inner and outer conflicts? Yes ___ No ___
20. Help students develop goals for the future? Yes ___ No ___
21. When you think of your school, what is the first thing that comes to mind?

    ____

    ____

IMPORTANT FACTS

1. It is far more efficient and economical to develop individual decision-making skills about drug use than it is to develop treatment programs for the habilitation of drug abusers.
2. Schools spend 96% of their time on academic learning and only 4% on social/emotional learning.
3. More money is spent on vandalism than on textbooks.
4. 10% of our nations high school seniors are daily marijuana users, consuming an average of 3½ joints every day (from statistics released by the National Institute on Drug Abuse, 1980).
5. From 1972-1979, experience with marijuana and cocaine has doubled among 12-17 year olds (National Institute on Drug Abyse, 1980).
6. The effects of drugs on those in the early stages of psychological and physiological development can be more pronounced and persistent than on mature adults.
7. The average "street marijuana" is four to five times stronger now than it was in the early 60's.
8. The more intelligent and better educated users lose far more brain power than the less intelligent or poorly educated marijuana smokers. "The more you have, the more you lose."
9. About one out of seven people who use chemicals (alcohol, marijuana, etc.) will eventually become chemically dependent on their chemical of choice.

GENERAL CONCEPTS

1. Schools are for the students. Schools should be child oriented.
2. Each learner must beome actively involved in the learning process.
3. No one changes their behavior unless they expect to benefit from the behavioral change.
4. Many students who have problems want counseling, but are afraid of peer pressure if they openly seek help.
5. Your role is to help, not punish.
6. Drug and alcohol problems are community problems, not just school problems, or police problems, or parental problems.
7. Poor home life does not mean that the student is beyond help or hope.
8. Understanding normal developmental tasks, especially of the critical adolescent period, and characteristics of high risk individuals can make teaching and program administration more meaningful and successful. (See following two pages).

God grant me the serenity to
accept the things I cannot
change --- the courage to
change the things I can --
and the wisdom to know
the difference

DEVELOPMENTAL TASKS OF ADOLESCENCE (Age approximately 12 to 18)

TASK	Some Typical Activities During Task Accomplishment	Some Ways Drinking and/or Drugs May Intervene in Task Accomplishment
DEVELOPMENT OF A PHILOSOPHY OF LIFE Acquiring adequate information, balanced attitudes, and constructive values as a guide to behavior—an outlook on life.	A person may choose to live by a work, religious, social service, or pleasure ethic; adopt transcendentalism as a driving life force; or turn to what he or she feels is an ecologically sound way of life. One's basic outlook is based on assimilated information and attitudes and on behavior.	Part of one's outlook includes a view of the role of drinking. A person may have uncritically assumed a drinking practice, have hangups regarding drinking, or not know how to drink. A person who choses to live by a pleasure ethic may prefer intoxication to sobriety, some religious ethics dictate total abstention from alcohol.
DEVELOPMENT OF PEER GROUP RELATIONS	Practice in developing social skills, such as dating and organization of or participation in clubs, gangs, social events, etc.	Drinking may seem the way to gain peer acceptance. It may be the focus of social events.
Achieving new and mature relations with age-mates of both sexes. Achieving a masculine or feminine social role.	In today's world, this task may be more perplexing than in decades past. Females must define individually what being a woman means to them in choice of career and style of homemaking. Males also must sort options that have not always been considered appropriate male roles.	To some males, drinking may symbolize masculinity. To some females, drinking may be thought to make one sexy or to be a bold departure from the older generations' view of ladylike behavior.
DEVELOPMENT OF PERSONAL INDEPENDENCE Accepting one's physique and using the body effectively.	Concern with physical appearance—acne, obesity, etc. Comparison of own personal appearance with appearance of others.	Alcohol may be used to alleviate anxiety about physical appearance.
Achieving emotional independence of parents and other adults.	Emotional and economic independence are both symbolized by one's ability to earn money, thus severing some of the dependence on adults.	Drinking may symbolize rebellion against parent or adult authority, It may be something to do when unemployed or bored.
Preparing for marriage and family life. Preparing for an economic career.	Responsibility for decisions about careers, mates, expenditures of time and money, etc., become the responsibility and prerogative of the adolescent.	Alcohol may be used to alleviate anxiety about making decisions or taking actions that may have long-term implications. With economic independence comes the ability to buy one's own drink.
		Just as with other adult practices, adult drinking practices may be emulated. Thus, drinking may signify rite of passage into adulthood.

Source: Reference 8.

SEVEN DEVELOPMENTAL CHARACTERISTICS
OF
HIGH RISK INDIVIDUALS

Attitudinal Skills	Seven Goals of Prevention/ Intervention Programs
1. Low identification with Viable Role Models. This refers to a person's reference group and self concept. The vulnerable person does not see himself as like (or the same as) people whose attitudes, values and behaviors allow them to "survive" in their total environment.	1. Strengthen identification with viable role models.
2. Low identification with and responsibility for "family" processes. When poorly developed, a person does not identify strongly with things greater than himself (e.g. relationships with another person, in-group mankind, God, etc.). He does not see that what he does affects others. This refers to shared investment in outcomes, shared responsibility for achieving outcomes, and accountability to others for behavior.	2. Strength identification with and responsibility for "family" processes.
3. (High) Faith in "Miracle" solutions to problems. This refers to the skills and attitudes necessary to work through problems and believe that they can be solved through application of personal resources. When poorly developed, a person believes that problems have been escaped when he can't feel them (drugs, alcohol, etc.) anymore. He does not believe that there is anything he can do about the present or future.	3. Develop problem-solving abilities.
Behavioral Skills	
4. Inadequate intra-personal skills. This refers to the skills of self discipline, self control, self assessment, etc. Weaknesses in these areas express themselves as: inability to cope with personal stresses and tensions, dishonesty with self, denial of self, inability to defer gratifications, etc.	4. Strengthen or develop intra-personal skills.
5. Inadequate inter-personal skills. This refers to ability to communicate, cooperate, negotiate, empathize, listen, share, etc. Weaknesses in these areas express themselves as dishonesty with others, lack of empathic awareness, resistance to feedback, inability to share feelings, give or receive love or help, etc.	5. Strengthen or develop inter-personal skills.

Behavioral Skills (cont.)

6. Inadequate systems skills. This refers to the ability to recognize to the limits inherent in a situation (responsibility) the ability to adapt behavior to a situation in order to get one's needs met (adaptability) constructively, etc. Weaknesses in these areas express themselves as irresponsibility, refusal to accept consequences of behavior, scapegoating, etc.	6. Strengthen or develop systems skills.
7. Inadequate Judgmental Skills refers to the inability to recognize, understand and apply relationships. Weaknesses in this area express themselves as crises in secual, natural consumer and drug environments, repetitious self destructive behaviors, etc.	7. Develop judgmental skills.

ADMINISTRATOR'S ROLE

Administrators always play key roles in the success of any program. This program is no exception.

In 1977, the administrator's responsibility to see that the district had an appropriate health education program was spelled out in Section 804 of the Education Law. It states that "instruction regarding alcohol, tobacco, and other drugs...shall be designed...with the purpose of developing desirable health behavior, attitudes, and knowledge as well as self-reliance and problem-solving capacity." With this legislation, it became apparent that administrators might wish or need to:

1. Encourage updated curriculum about drugs within their school systems.

2. Formulate a descriptive policy on smoking, drinking, and drugs with a firm, but flexible plicy for treatment or punishment of students, staff and visitors.

3. Provide for inservice (credit?) training in the alcohol, smoking, and drug areas for staff and parents.

4. See that the library contains up-to-date material on the subject of drug use and abuse.

5. Set up cessation programs for drinking, smoking, and/or drugs. These could be mandatory for student violators, and optional for those who would like to quit, but feel that they need assistance.

6. Set up a "diversion" program for students who need counseling for disciplinary problems of any kind. It could be mandatory for certain violators, but it would be available to any student who wanted to enter it on a voluntary basis.

7. See to it that a drug and/or alcohol counselor is available to students even if it is only on a part-time basis.

8. Encourage parents to formulate a set of rules and guidelines for conduct at parties and school events. Students should be consulted when formulating these guidelines. (See sample from Wyoming Seminary on succeeding pages).

9. Learn to recognize patterns of job performance deterioration due to alcohol and/or drug abuse by teachers and staff. (Helpful lists can be found after the guidelines on the next two pages).

10. Encourage teachers to incorporate positive behavioral techniques as well as teach how to say NO to negative behavioral influences.

A healthy school organization and enviroment reveals a staff and students who are better equipped to deal with the daily demands they face. Such a school often has the following among its positive goals:

1. Offer students more alternative programs giving each student an opportunity to feel successful and experience success in at least one area.
2. Develop a participatory problem-solving process which includes teachers, staff and administrators.
3. Develop human relations programs (peer counseling, individual and group counseling, referral networks) to provide support and assitance to students and staff when indicated.
4. Develop a positive change in student and staff attitudes toward the school allowing everyone to feel the environment as a pleasant one which makes them feel productive and useful.
5. Provide administration and community support for teacher's activities in the classroom.
6. Adopt responsive disciplinary rules that everyone knows and understands.
7. Have a fair, consistent leadership, allowing teachers and staff to function in a stable and positive environment.
8. Avoid labeling students and putting students in speical groupings.
9. Encourage and design structures and activities to facilitate parental involvement in the school.
10. Offer programs which allow for more experiential learning opportunities for students.

Often, it is ultimately the role of the school administration, hopefully not single-handedly, to see that such goals are carried out effectively by appropriate personnel within the district.

GUIDELINES

I. Purpose of Guidelines

A. Guidelines concern the shared responsibilities of parents and teens in developing a healthy lifestyle. When teens and parents understand the guidelines,then they will be able to more effectively cooperate in the area of parties and informal get togethers. Also, it is important for parents to communicate with one another without censure from their children. Parents need support and encouragement from each other to feel confident in arriving at wise decisions regarding teenage activities.

B. We believe that meetings, literature, and communication can and should be constructive and non-blaming of our parents, teachers, and students. We encourage the development of a policy such that any parent will be called by any school person and/or any other parent without fear or threat of legal suit when any unusual behavior followed by reasonable investigation indicates the presence of drugs or alcohol.

II. School Events

Parents and students agree to support and reinforce school regulations for all school-based events as well as regular school hours.

III. Social Life Outside of School

A. Curfews

1. School nights: Hours are determined in each family by parents and child.
2. Weekends: 10:30 P.M. for eighth graders
3. Curfews are bound to vary, depending on the people you are with and where you are going. Parents should help children develop responsibility by allowing children some say in curfew time. Students feel that the children should be responsible enough to know that if they have a lot of homework, they should do it before going out, or plan to come in early.

B. Parties

1. Planning

    a. Social events should be well-planned activities.
    b. The host should know the guests - no strangers.
    c. The host should set the limit on the number of guests in planning with his or her parents.
    d. There should be a definite starting and ending time.
    e. The number of chaperones depends on the size of the party, with one couple for every ten kids.
    f. If there are no written invitations, host's parents will notify parents of guests about the details of the party. The host informs the guests.

B. Parties

1. Planning (cont.)

f. Written invitations are easiest and preferred.
g. If a guest will be late, host and host's parents should be notified.
h. Guests should find out in advance if hosts' parents will permit them to bring a friend.
i. Party should be where people feel free to move about - not where there is fine china or valuable antiques.

2. At the party

a. Alcohol and drugs are not available or served.
b. If you leave the party, you can't return, and your parents will be notified.
c. If you want to leave the party early, you call your parents to arrange to leave, and the host's parents check with your parents.
d. If someone is caught doing something they shouldn't be, then the host's parents will call the parents of the offender and let the offender's parents handle the situation. No other children or parents need to be notified. The group shouldn't be blamed for the actions of one or two.
e. The host's parents should be at home. It's okay for parents to come into the party once in a while, but not to "camp out" in the party.
f. The host should see that everything goes smoothly, keep things under control, and provide the music and refreshments: munchies, pizza, and soda.

3. Guest's responsibilities

a. You should be able to reach your parents or have an alternate person to call if needed.
b. You should stay within the physical setting determined by the host.
c. You should respect property.
d. You should obey the rules even if you don't agree with them. (If you know the rules beforehand and don't agree with them, maybe you should stay home.)
e. You should not bring drugs or alcohol, and if you see a liquor cabinet, don't touch it.
f. You should call home to let your parents know if you are going to be late.

C. Parents need to be aware that they can be held liable to civil and criminal charges if injury to a minor results from underage alcohol consumption or illegal drug use on their property.

D. Parent-child cooperation in coping with problem situations will be aided considerably if parents and children know where to reach each other by telephone, and if parents are awake or expect to be awakened when a teenager comes in at night.

IDENTIFICATION AND INTERVENTION

In a school setting, if you see a student or staff member with a cluster of these problems, you are very likely to have a person who himself or whose family has an alcohol or drug problem. Anyone can identify a skid row client because we don't drink like they do and, therefore, we're okay! Because of this, people in positions to do something about early identification and intervention often fail to do so. Treatment would be much easier, carry less stigma and cost less money if each individual would identify and refer clients early!

Symptoms of Substance Abuse

1. Increase or Decrease in tolerance - to any drug.
2. Extreme personality changes.
3. Pattern changes (excellent or poor student)
4. Hiding bottles or pills (food hiding).
5. Chronic daily use.
6. Denial (get bent out of shape when try to talk to them about it)
7. Interferes with person's life in major way (family, money)
8. Make promises never to use or get again.
9. Do things when drinking or under the influence person normally wouldn't do when sober.
10. Inability to delay gratification.
11. Adults who act like cartoons (overcompensate or act like some character role they have been brought up with. This becomes more exaggerated as the length of addiction becomes longer.)
12. Kids picked up for DWI twice or young female picked up for DWI once.
13. Loss of control.
14. Blackouts.

Basic Principles of Intervention

1. No one volunteers for treatment.
2. Denial is to be expected. Those around the person participate in the cover up.
3. There is an emotion/intellect split when drinking or under the influence of a drug. Talk to person when s/he is fairly straight or sober.
4. Treatment is exactly like any other disease.
5. Average addicted person is going to make your life miserable when you try to intervene.
6. You are going to need support.
7. Relapse is common like diabetes and epilepsy.
8. Don't take it personally, you wouldn't take a seizure by an epileptic personally.
9. Don't get frustrated.

The following pages may be combined or used individually to help with the task of early identification and intervention.

POSSIBLE SYMTOMS OF DRUG USE IN SOME/NOT ALL PEOPLE

Change in attitude or behavior pattern

Red streaked eyes--user may blame on cigarette smoke, uses Visine to help clear eyes

Dilated eyes

Uses spray to cover smoke odor

Uses gum or mints to cover breath

Obnoxious or belligerent attitude (parent blames on being a teenager)

Withdraws from family life functions/lack of motivation

Sleeps long hours during day and "crashes"/ disturbances in sleep

Can't sleep during early hours of normal sleep time--able to sleep after 3:00 A.M.

May chill easily/may get shakes

Usually goes right to own room upon entering house and closes door

Sneaks through window at night and comes back in same way

Loss of appetite or may be obsessed with junk food only

Blames others for his/her problems at school or home

Missing allergy or other pills from home to sell to others

Unexplained dents in car (usually blamed as "school parking lot accident by someone else")

Sore throats, bronchial cough, runny nose, asthmatic wheezing, chest pains

Pale, pasty coloring/possible skin rashes

Slurred speech

Rapid speech/no slow down or flat, expressionless speech

Poor memory/impaired ability to concentrate

May not answer when spoken to because is "spaced out"/blank facial expression

Can lie to you and you will swear user is telling truth

Missing money or items that can be sold

Decreasing performance in schoolwork and sports

Ditching

Incense use in room

Needle marks on arms and legs

Wearing sunglasses at inappropriate times

Association with known drug users

Stomach or colon problems

Nausea, sweats, trembling

Signs of mononucleosis

Acute anxiety sometimes accompanied by paranoid thoughts

TEACHER'S ROLE

The key change agent in the educational process is the teacher. Therefore, in prevention programming it is important to provide training for teachers so that they will be better equipped to create a humanistic environment for their students. By so doing, change in students can be promoted so that they are less likely to feel the need to seek gratification through drug/alcohol abuse and other self-destructive behaviors.

Responsibilities of a parent who wishes to prevent substance abuse in children s/he teaches include to:

1. Contribute to the child's affective, as well as cognitive, development.
2. Help the learner develop personal living skills.
3. Help the learner acquire creative decision-making skills to cope with an increasingly complex world.
4. Provide methods and develop techniques to make learning more relevant so that students see life as meaningful.
5. Demonstrate that s/he cares about young people as individuals.
6. Show sensitivity to students' non-academic needs as well as academic needs.

Awareness of the assumptions upon which educational theories are based can influence a teacher's effectiveness. These major assumptions are:

1. Learning is defined as a change in behavior (which includes knowledge, attitudes, values, etc.)
2. Participants in the learning process have developed self-concepts that affect their behavior.
3. Participants in the learning process use some of their own reactions and experiences.
4. Learning requires activity.
5. People learn what they want to learn.
6. Learning is influenced by the physical and social environment.
7. Learning is enhanced when the learner accepts responsibility for the learning.
8. Learning is enhanced when it provides opportunity to apply what is learned.
9. Learners are motivated when they understand and accept the purposes of the learning situation.
10. Learning is enhanced when the learner feels accepted by the teacher.

Teacher's Role
(Cont.)

11. Learning is enhanced when the learner is able to associate new knowledge with previous knowledge.

12. Learning is influenced when the learner can see its relationship to something else which is meaningful to him/her.

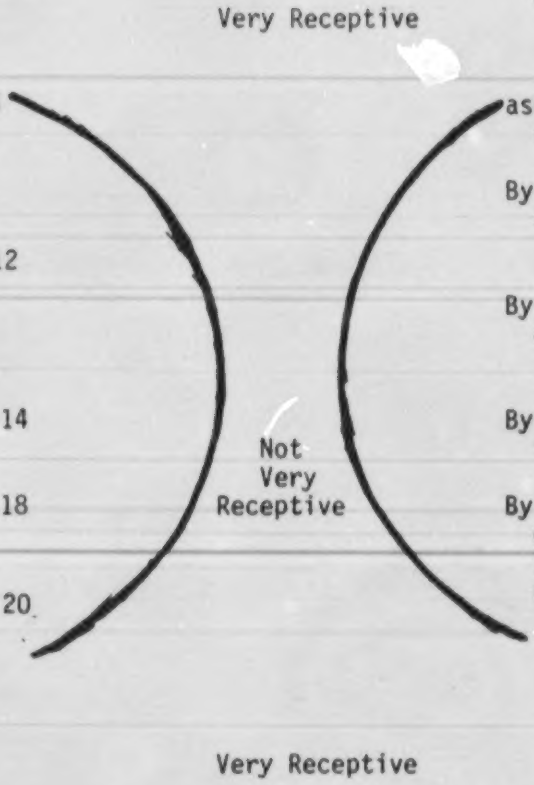
13. The more time a student spends successfully on a task, the higher the achievement.

14. Receptivity to learning varies with the age and stage of development of the learner. (See illustration of the following page which may be duplicated for inservice programs.)

RECEPTIVITY TO LEARNING

AGE

- 0 - 5
- 5 - 12
- 12 - 14
- 14 - 18
- 18 - 20


Very Receptive
Not Very Receptive
Very Receptive

CHARACTERISTICS

- ask lot of questions; curious; feel good about themselves
- By 2nd grade-½ of kids did not feel loved or special
- By 4th grade-school is less concerned with the whole child
- By 8th grade-each teacher sees the child fewer minutes/day
- By 12th grade-teachers really get specialized and become teachers of subject matter rather than of children

From work by FRED STREET

Teachers Role Cont.

The teacher is a true catalyst in the drug program and serves as an important link between the administration and the student body. The teacher needs to:

1. Keep up-to-date on the teaching methods considered to be most effective by teachers and other professionals in the substance abuse prevention field.

2. Learn preventive techniques as well as intervention techniques. (See following page on "Five Principles of Intervention".)

3. Take advantage of inservice programs, books, booklets, TV, radio, magazines, newspapers, etc. to stay informed about substance use and abuse.

4. Incorporate discipline, responsibility, and judgment making skills into classroom work whenever possible. The great percentage of students will forget much of the factual information that they have obtained in school, but they will retain attitudinal and behavioral skills for a much longer period of time.

5. Emphasize individual decision making about the use of drugs.

6. Never attempt to bluff students. If your bluff is discovered, you will lose your creditability.

7. Learn to recognize the symptoms of the alcohol and/or drug abusers.

8. Provide a classroom enviornment where students may examine and clarify their own feelings and attitudes about the use of alcohol and/or drugs.

9. Make copies, distribute to each student, and encourage them to share the following pages with their parents:

   "The Responsibility of a Host"
   "Composition of Some Alcoholic Beverages"
   "Blood Alcohol Chart of Body Weight vs. Drinks Consumed"
   "How To Keep The Life of The Party Alive"
   "Methods to Control Drinking Patterns"
   "Personal Plan of Action for Non-Smokers"

FIVE PRINCIPLES OF INTERVENTION

1. The important persons in the life of the chemically dependent person should be involved in the intervention. This includes all of the immediate family members, possibly the employer or work supervisor of the person, and close friends if they have first hand knowledge of the person's behavior and chemical use.

2. All of the important persons should write down specific data about events, and behavior involving the chemical use of the dependent person.

3. All of these persons should then tell the chemically dependent person how they feel about what has been happening to their lives, and the information that they give must be given in a nonjudgmental way.

4. Choices for help such as joining A.A., going to treatment and seeking one-to-one counseling should be offered to the dependent person. If the person absolutely refuses all of these choices, the people involved in the intervention must insist that s/he answer the question. "What happens if you can't quit using the chemical?" They should make a firm and clear commitment to what their response will be if the person resumes chemical use. It is helpful to try to reach an agreement with the person that if he begins to use alcohol or other mood-altering substances again, he will then seek help.

5. If the person agrees to seek help immediately, appropriate help should be available.

THE RESPONSIBILITY OF A HOST

The repeated role of hosts and hostesses in our homes gives us ample opportunity to develop good codes which can set a standard for careful moderate and responsible drinking, codes which would recognize that overdrinking is a form of gluttony, and that any value to be found in drinking, we remember, takes place only when the social unit gains; it is not egocentric drinking. Beyond an ascertainable point in the accumulation of alcohol in the blood stream, a point that can be demonstrated in the laboratory, all the so-called values of social drinking are gone.

Generally authorities are not against drinking, but rather they're in favor of safe drinking. It is possible for hosts and hostesses of parties to keep their festivities from becoming sloppy affairs which end up with drunk drivers trying to negotiate their way home late at night. The attitude of the host or hostess should not be to become an alcohol pusher. For example, they should not make doubles. It would be better to serve a sour cream dip with vegetables rather than the traditional salty snacks which make people more thirsty. High protein foods such as shredded beef dip also slow absorption.

A helpful code for a host and hostess would include such rules as:

1. Never give a party for the main or sole purpose of drinking. Make sure that parlor games or other diversions are available so that drinking is not the party's only function.

2. Always serve food with alcoholic drinks. Plenty to eat should be available to keep guests from feeling the effects of liquor too quickly.

3. Always serve the meal without prolonged delay if alcoholic drinks precede it.

4. If alcoholic drinks are served, serve always with them, and as attractively, non-alcoholic drinks. Make sure there is an adequate supply and variety of non-alcoholic beverages available rather than simply coffee and soda.

5. Never violate courtesy by allowing pressure to be put on guests to drink if they do not wish to do so. Do not make guests feel uncomfortable if they do not have drinks in their hands.

6. Never delegate to cocktails the host's responsibility to create an atmosphere and to encourage relationship conducive to wholesome recreation.

7. Avoid drawing attention to a guest who is known to have the illness of alcoholism.

Too often the people throwing the party let their hair down and have too much to drink themselves while forgetting that guests have to drive and that some people do not handle alcohol as well as others. Guests should also do their part to pace their drinking and keep from becoming intoxicated by alternating alcoholic and non-alcoholic drinks during the evening and drinking no liquor for an hour before heading for home. For examples:

"Pile Driver"

4 oz. orange juice
4 oz. quinine water
Over ice in a tall galss

"Lime Fizz"

1 oz. non-alcoholic bitters
1 tsp. grenadine
½ squeezed lime
1 egg white
Blended with cracked ice & mixed with club soda

HOW TO KEEP THE LIFE OF THE PARTY ALIVE

After the party:

1. Make the suggestion to your guest that you drive him home. He can come back for his car at a later date, when he's able to drive.

2. Suggest that he stay overnight at your place. Even if it's inconvenient, you may be saving his life.

3. If he insists on driving, take away his car keys. Your friend may resent it at the time but will appreciate it later.

4. Physically restrain him if he still wants to drive. If it sounds drastic--think about this: Wouldn't you rather sound drastic than be sorry tomorrow?

5. Call a taxi. Pay for the cab yourself. Your friend can't object to a free ride home.

6. When other measures fail, call the sheriff to prevent his driving. You may be shocked by this suggestion, but any measure must be taken to prevent the drunk from driving. There's little chance your friend will be arrested and the sight of an officer may make him act more rationally.

ANYTHING YOU CAN DO TO PREVENT THE DRUNK
FROM DRIVING IS THE RIGHT THING TO DO

METHODS TO CONTROL DRINKING PATTERNS

The State of Vermont, in the excellent "Project Crash" has summarized some positive steps one can take to get or keep drinking under some control. In discussion of opinion surveys, the instructor may wish to refer to this list in discussion of concerns expressed by motorists.

1. Do not drink on an empty stomach. Eat something before you drink, solid foods preferably. Or eat, as you drink. It is always best to have balanced and nutritious meals. If you're invited out to a strictly cocktail party, eat before you go.
2. If you are overly tired, take a nap, instead of a drink.
3. If you are faced with a difficult decision, do not try to settle it over a drink. Get away from it all... for a little while. Do some form of physical activity, walk, jog, or even skip rope. Then go back to the problem. It's possible you may wish to celebrate with a small drink.
4. Learn to sip your drinks. Do not drink fast. Enjoy your drink. Is that why you drink in the first place? You can very well do without that second or third drink.
5. Never force yourself to drink more because it is the "thing to do". I'm sure you don't wish to be an alcoholic. That's what alcoholics do.
6. When you do reach your drinking capacity...STOP!!! "Water" your drinks to avoid the embarrassment of an empty or no glass in hand if that helps you.
7. Delay your drink. Wait for the next round.
8. Take time off from drinking. Declare a truce of a week, month, whatever, to show yourself you can do it.

   ...You should learn to stop temporarily your drinking in private as well as in public.

9. If you find it difficult to sit around watching television or reading without a drink in your hand, try alternating. Have a drink, then a glass of soda pop, ice water, maybe even coffee or tea. In this way, you will never find yourself empty-handed, and you will be helping to solve your drinking problem.
10. Make sure you drink only when you enjoy it. Don't let anyone force a drink on you, unless you want it. Say "NO" when someone suggests "How about a drink, Joe?"
11. Carrying around some slogans that will help you set drinking limits such as:

    Not before five, or
    Not during the week, or
    Never on Sundays, or
    Never when I have to drive.

    In the same manner, decide when you are going to drink. This may be just as important. It helps keep you in control of your drinking.

12. Try a change of pace. Have a glass of beer or wine with your meal. (They usually have a lower alcohol content by volume. They also absorb more slowly into the bloodstream.) This sounds pretty tame to the Scotch and water drinker, but you may be able to cut down your "heavier" drinking in this manner.

13. Do not cut yourself from drinking situations. Just drink less.

14. Give yourself a reward during the first weeks. Take the money saved from drinking less and buy something special --- clothes or dinner or a good movie --- or a good book. Or, even permit yourself to sleep later.

15. Find a substitute beverage in place of alcohol, such as a tasteful fruit juice or soft drink.

16. Review your progress often. Go over the situations which are difficult or particularly tempting. Recall your reactions. Think it all out. Stay on top of it mentally. You should make an effort to analyze each coming day and to predict situations and your possible reactions.

17. Be on your guard against such excuses for drinking as headaches, tired feelings, loneliness, self-pity, or whatever else may provoke your craving. Recognize these signals and head for the aspirin, the couch, or the fresh out-of-door..... not the bottle.

18. Make an effort to try new activities that substitute for "alcohol situations." A new sport, a new hobby, even a new route to walk. You can spend more time with your family, attend sports events with children, etc. Spend more time with your spouse and relatives and your non-drinking friends.

19. Keep reminding yourself that no one is making you do it. You and you alone want to control your drinking.

20. In addition to these, if you drive you need to regulate your drinking by:

    a. Adjusting the times when you drink and the amount you consume.

    b. Observing the one-for-one rule... wait one hour after each drink.

PERSONAL PLAN OF ACTION FOR NON-SMOKERS

Non-smokers have suffered in silence for years, enduring the annoyance discomfort and allergic reactions of second hand smoke. That day is over and the tide is changing. The non-smoker is speaking up for his rights and he is beginning to translate his feelings into action.

BE VOCAL: Express your feelings about smoking. Be honest with family, friends and business associates. Let them know how you feel about their smoking expecially as it conflicts with your breathing rights.

BE VISUAL: Use no smoking decals, buttons, bumper stickers, posters and signs to reinforce your vocal objections. Frame the Non-Smoker's Bill of Rights in a conspicuous place.

REMOVE INVITATIONS TO SMOKE:

Remove all ashtrays and utilize a sign, decal or tent card in their place.

IN YOUR CAR: Request passengers not to smoke. Utilize a decal on your dash board. Offer to stop during the trip for smokers who feel they must smoke.

ON INVITATIONS:

Along with R.S.V.P., why not add N.S.P. (no smoking please)

AT WORK: Utilize posters, decals, tent cards and signs to reinforce your stated position on smoking. Work through management or employee organization to provide smoke free sections in cafeterias, lounges, restrooms. Provide visual materials to fellow employees. Assist interagency councils and voluntary agencies seeking to work with business and industry in smoking education or cessation programs.

WHEN TRAVELING:

Always request seating in the non-smoking section. Express your approval of separate sections for non-smokers and smokers and your disapproval when they are not provided or are inadequate. Speak up when regulations are not enforced.

IN RESTAURANTS:

Request seating away from smokers. Suggest that non-smoking sections be provided where none exits. Request that ashtrays be removed from your table. Whenever possible patronize restaurants that honor non-smokers rights.

IN WAITING ROOMS:

Encourage your physician and dentist to support no-smoking regulations in all health care facilities. Offer to provide visual materials for display in health care facilities. Work with interagency councils and voluntary agencies in supplying such materials.

IN HOSPITALS: Request a room with a non-smoker. Ask visitors to abstain if no policy exists on smoking in rooms. Prop up a tent card on your bedside table.

COLLEGE AND UNIVERSITIES:

Research current school policies on smoking. Bring the matter of smoking in class to a student vote. Request that smoking be prohibited during class sessions. At the very least, request a non-smoking section in the classroom. This should be extended to cafeterias, lounges and other public areas.

AT MEETINGS: Propose a non-smoking policy or resolution. If this fails, request that no smoking sections be set up or frequent breaks be provided. Remove ashtrays from meeting rooms. Utilize a pass around card as follows:

A POLITE AND REASONABLE REQUEST

(please pass it on)

There are some of us at this gathering who suffer discomfort and annoyance from tobacco smoke. If you are a smoker, we will deeply appreciate your refraining until adjournment, or stepping outside to smoke. Thank you for your consideration.

PUBLIC SPEAKERS:

Request that there be no smoking during your presentation.

SHOPPERS: Patronize smoke-free stores and commend personnel and owners on their no-smoking policies.

PUT YOUR FEELINGS IN WRITING:

A letter may seem like a little thing but it can produce powerful results.

Write letters to the following:

1. Supermarkets, stores, restaurants requesting no-smoking policies. Consider using petitions for same.
2. Hospitals and Health Care Facilities regarding their no-smoking policies.
3. Newspapers make an excellent forum on the problems of smoking.
4. TV and radio stations commending them for anti-smoking spots and requesting greater use.
5. Send letters to legislators in support of anti-smoking bills and regulations. Refer to bills by name and number and ask the legislator to support it.

   Request your legislators position on the bill.

   Give reasons for your position.

   Justify your position with facts.

   Send telegrams as a reminder to legislator where the facts are already known.

ABOVE ALL BE POLITE IN ALL OF YOUR ACTIONS. AVOID A KNOW IT ALL, SANCTIMONIOUS ATTITUDE. BE A GOOD LISTENER AND HEAR THE OTHER SIDE OUT. EMOTIONS CAN RUN HIGH IN CERTAIN SITUATIONS AND A FIRM BUT POLITE DEMEANOR BOLSTERED BY SOUND FACTS CAN HELP AVOID TURNING PEOPLE OFF BEFORE THEY HEAR YOU OUT. AT TIMES ONE MUST BE PREPARED TO ACCEPT A COMPROMISE AND WAIT FOR THE NEXT OPPORTUNITY.

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We gratefully acknowledge the use of materials from the Non-Smokers' Liberation Guide published by G.A.S.P. - Group Against Smoker's Pollution, College Park, Md., in preparing the above.

RESPONSIBILITIES OF BOTH ADMINISTRATORS AND TEACHERS

1. Set realistic goals
2. Set expectations rather than demands.
3. Develop an understanding of the social and personal dynamics which foster substance abuse and misuse.
4. Make use of the numerous in school and outside resources to supplement and reinforce your own teachings and ideas (administrators, teachers, guidance counselors, drug counselor, school nurse, parents, students, board members, law enforcement agencies, clergy, hospital personnel, mayor, mental health agencies, drug and alcohol abuse agencies, youth bureau, etc.)
5. Identify a core group of people to support your program and to act as reinforcement against negative resistance. There is strength in numbers!
6. Make readily available accurate and up-to-date information pertaining to alcohol, cigarettes, and drugs.
7. Make yourselves readily available for advice, opinions, information, etc.
8. Learn the legalities of dealing with offenders.
9. Learn emergency procedures to handle overdoses, etc.
10. Show respect for others. Even if you feel superior, try not to show it.
11. Definitely do not adopt a "Do as I say, not as I do" policy. It simply won't work!
12. Keep a sense of humor.
13. Be fair and consistent as much as possible.
14. Know the differences between discipline and punishment (see the following page).
15. Encourage the following set of activities to be implemented into as many subject areas as possible.

DEFINITE DIFFERENCES BETWEEN THE TERMS "DISCIPLINE AND PUNISHMENT"

	Punishment		Discipline
1.	Expresses power of a personal authority. Is usually painful and based on retribution or revenge (what happened in the past). Is arbitrary.	1.	Based on logical or natural consequences expressing the reality of the social order (rules which must be learned in order to function adequately). Concerned with what will happen now (the present
2.	Is imposed. (Done to someone). Responsibility is assumed by the punisher.	2.	Responsibility is assumed by the individual (Done by). Comes from within. Is desired.
3.	Options for the individual are closed.	3.	Options are kept open so individual can choose to improve behavior.
4.	A teaching process which usually reinforces failure identity. Essentially negative and short term without sustained personal involvement.	4.	An active teaching process involving close, sustained, personal involvement. Emphasized teaching ways to act that will result in more successful behavior.
5.	Open or concealed anger.	5.	Friendly
6.	Easy or expedient.	6.	Difficult and time consuming.
7.	External locus of control.	7.	Internal locus or control.
8.	Breaks involvement.	8.	Maintains involvement.

Activities

Art
POSTER ASSIGNMENT OR CONTEST

Time Required: Three days to two weeks

Objective: To develop students' visual composition and drawing skills; to increase students' awareness of the ways in which a message can be communicated through art work.

Method: In a unit which relates to advertising or the use of art as a persuasive medium, ask students to describe a variety of experiences in which they have done something because of pressure from their friends. Suggest that clothing styles, vocabulary expressions, and attitudes about certain subjects are all examples of things which can be influenced by friends. Using the theme of "Be Yourself" or "It's Okay to Say No," ask students to develop posters which would encourage their peers to become more aware of the way in which peer pressure influences behavior. Posters, when finished, can be displayed around school or in the community. Prizes and publicity for particularly effective posters might create additional enthusiasm for this activity.

Art
JUNIOR HIGH IS . . . —AN ORIENTATION BOOKLET

Time Required: Two weeks

Objective: To develop students' abilities to communicate a message through art; to increase students' awareness of how one part of a design relates to the purpose of the whole.

Method: Bring to class two or three examples of books which describe a particular concept primarily through drawings. (Charles Schultz' *Happiness is Walking Hand in Hand* is a good example). Explain to your students that they have an opportunity to help with the orientation of next year's seventh grade students by developing a booklet which will be duplicated and distributed to students who are currently in sixth grade. The purpose of this booklet should be to help the new students understand what junior high is *really* like. As a class, list situations which reflect the realities of junior high, such as forgetting your locker combination; being late to class, trying to make friends in a new social group; working hard on homework; deciding whether or not to smoke, drink, or make-out at a party. As individuals or in small groups, ask students to design and create a picture and tag line which would effectively describe to incoming students what situations await them. Drawings might also suggest positive ways for new students to handle those situations. As the pages develop, allow time for the class to discuss the issues involved, especially those which relate to how students make decisions about their behavior.

THE IMPACT OF "PUT-DOWNS" ON PARTICIPATION

Phys. Ed.

Time Required: One to three days

Objective: To increase student awareness of "put-downs" on students' participation in sports activities.

Method: After at least two weeks of team sports activities, ask students to individually write down one "put-down" they have heard sometime during the team sports activities. Explain to the students that these put-downs will be read out loud to the rest of the class. Collect the "put-downs," and one at a time, let students draw one from the pile, read it to the class, and describe how they would feel if someone had said such a statement to them. Time permitting, role play PE situations in which "put-downs" are likely to occur; role play ways in which the situations could be handled without the use of a "put-down." Ask students to think of ways in which "put-downs" pressure a person—especially in a team sports setting. Explain the concept of self-image to students, perhaps by telling the IALAC (I Am Lovable And Capable—Sid Simon) or Claude Steiner's Warm Fuzzy Story. Ask students to draw a relationship between the strength of a person's self-image and his/her willingness to participate in sports activities. Ask students to individually write down positive statements which would encourage rather than discourage them from playing with others in the class. Collect these statements; without comment, read them out loud to the class. Save the positive statements. When appropriate or necessary, suggest that students choose a positive statement rather than a "put-down" as a way of communicating to someone else in class.

LIFE STYLE & LEISURE ACTIVITY

Phys. Ed.

Time Required: One to three days

Objective: To encourage students to see how a peer group can influence the choices a person makes regarding leisure activity and lifestyle.

Method: During a discussion of lifetime sports, ask students to list several easily identifiable groups of people—drawing from both student cliques on campus to adult groups or circles within the community. Ask students to predict the types of leisure sports or activities preferred by each group. Through role playing, short written assignments, large or small group discussions, allow students to consider the pressure that can come when "everyone" does the same thing; identify ways in which group expectations can limit choices for individual behavior. Ask students to share experiences they have had when they have either unwillingly lived up to a group's expectations or did the opposite of what a group expected.

Health

THE LINE ACTIVITY

Time Required: One day

Objective: To provide students with an in-class demonstration of the power of peer pressure; to lay groundwork for future discussions on student behavior and health issues such as nutrition, drugs and alcohol, V.D., contraception.

Method: Ask one reasonably confident student to stand outside the door for a few minutes. Explain to the class that the purpose of this activity will be to try to convince the person outside of something that is not true. Draw two parallel lines on the chalk board, making sure that one is slightly—but noticeably—longer than the other. Designate seven or eight students to use whatever reasonable tactics they can think of to persuade the person outside that the lines are the same length. (Depending on your class, you might want to set some limits on "reasonable tactics.") Pick 3 or 4 members of the class to observe what happens when the person comes in and the persuading begins. Ask the person outside to come in; explain that while s/he was out of the room, the class began discussing the length of the two lines drawn on the board; ask the student to compare the lines in terms of length. Once the student announces that one line is longer, let the persuaders begin. Allow the activity to last no longer than five minutes, taking care that the student who is the object of the pressure does not feel overly put-down or threatened by the pressure from his/her peers. Call the pressure off at an appropriate point; ask the observers to report on what they saw; allow the student being pressured to share his/her feelings about the pressure; let those who were doing the pressuring tell how they felt about their role.

Ask the class to think of ways in which this activity represents situations which go on at school. With the class, develop a definition of peer pressure and discuss how it can influence a person's decisions regarding such health issues as drugs, sexuality, nutrition, and exercise. As a follow-up, allow five minutes of class time each day for two weeks for students to report incidents they have seen or experienced at school involving peer pressure. At the end of two weeks, review the list by asking students to share their ideas about ways to deal effectively with peer pressure. Make a list of these ideas and post it in the classroom.

HISTORICAL FIGURES

Social Studies

Time Required: Two days to two weeks

Objective: To increase student awareness of the personal, social, and historical factors relating to the lives and work of people influential in the development of the United States and other countries.

Method: Whenever appropriate to the curriculum, highlight the lives of individuals whose achievements influenced history and technology in spite of pressure from their family, friends, or community to abandon their work. Examples of both men and women from various ethnic backgrounds include: Father Junipero Serra, Cesar Chavez, Susan B. Anthony, Harriet Tubman, Jane Addams, Chief Joseph of the Nez Perce, Crazy Horse, Lewis and Clark, Fulton, the Sons of Liberty, and Columbus. Ask students to present skits, oral reports, or panel presentations to the class which emphasize the importance of the person's ability to persevere with his/her work, regardless of the pressure to stop. Ask students to share orally, through art work, or in a written assignment ways in which they face pressures similar to those encountered by the historical figures.

POLITICAL ELECTIONS & THE USE OF ADVERTISING

Social Studies

Time Required: Three days to one month

Objective: To examine the role of mass media (TV, radio, and print) as a means to influencing the voting behavior of individuals.

Method: During local or state-wide elections, ask students to collect samples of campaign literature and descriptions of TV and radio spots. Examine each in terms of the technique used to pressure the voter and its effectiveness in doing so. Invite a local advertising person to talk to the class about advertising techniques. As a class, design and conduct a campaign to influence students at school to make some kind of change in their behavior (perhaps encouraging students to say "no" to peer pressure). Contact local TV and radio stations and request special broadcasts of the "kid" spots of the 1979 National Drug Abuse Prevention Campaign; if possible, record these spots on videotape, using them in class as a source of ideas for the students' campaign at school. Ask students to compare their campaign to the political campaigns (and the Drug Abuse Prevention Campaign) they have observed, assessing the effectiveness of each. Allow time for students to determine whether or not their campaign influenced their own behavior in any way.

Language Arts

CHARACTERIZATION THROUGH ROLE PLAY

Time Required: One to three days

Objective: To increase students' awareness of characterization and plot.

Method: When a particular reading assignment deals with some type of decision-making situation and characters who are trying to influence one another, ask students to role play particular scenes which focus on both the pressure and the decisions. Encourage students to play out a variety of endings to each scene. Discuss the impact of these alternate endings on the plot and theme of the story. As a follow-up, ask students to share their experiences of making a decision under pressure in a short writing assignment.

Language Arts

WRITING ASSIGNMENTS ON THE THEME OF SAYING NO

Time Required: Three days to two weeks

Objective: To improve student writing and vocabulary skills

Method: Brainstorm with your class a list of the pressures students face as they make decisions about their behavior. As appropriate and necessary, define terms such as "peer," "pressure," "influence," "alternatives," "consequences" and discuss the meanings of related feelings such as frustration, confusion, irritation, anxiety, relief, and satisfaction. In the classroom, post both the list of pressures and the definitions of related terms and feelings. Encourage students to write in a personal journal (five minutes of class time per day for two weeks) about the decisions they make and the factors which influence their choices. Suggest that students use the posted lists as a source of ideas and assistance in their journal writing. Individually, or in small groups, ask students to write free style poems, songs, skits or prose which focus on the feelings they experience when they say "no" to a friend. Encourage students to share and discuss their work with their small group or the class as a whole. Keep a class record of the pressures and feelings students mention most in their writings and compare that list with the original lists developed by the class.

Math

STUDENT SURVEY

Time Required: Two weeks

Objective: To teach and/or reinforce student skills relating to data collection, organization, and display.

Method: Introduce this activity by asking students to share their knowledge of what a survey is and does. Provide examples of survey questions and results (perhaps summaries of recent Gallup or Harris polls). With students, brainstorm a list of possible topics for a survey of student behavior or attitudes. As a group, select an appropriate topic. (Ideally, it will relate in some way to peer or media pressure and students' decisions about their behavior). Depending on the writing ability of your students, develop a questionnaire as a class, in a committee, or by yourself with student suggestions for topics to be covered by the questions. With the class, discuss and decide on sampling, data collection, and data analysis techniques — making sure that each student is involved in as many phases of the survey as possible. Once the data has been collected, organized into tables, charts, or graphs, ask students to interpret the meaning of their findings. These interpretations can be shared with other students through Student Council, the student newspaper, or a special report from your math class to the rest of the student body and the faculty. Whenever appropriate, allow time for students to share their opinions, ideas, and experiences relating to the issues pertinent to the survey.

Math

RANK ORDERING OPTIONS FOR DECISIONS

Time Required: One to two days

Objective: To develop students' awareness of rank ordering techniques, to encourage increased computational skills.

Method: Explain the concept and use of rank ordering technique to your students. On paper, describe five decision-making situations relevant to your students and the pressures they face. Outline four to seven options for behavior in each situation. Examples might be:

A. What would you do if one day your best friend refused to talk with you?

____ refuse to talk to him/her?

____ ask him/her what was wrong?

____ talk to a friend who knows you both?

____ talk to your parents?

____ get mad and start an argument with your friend?

B. What would you do if all your friends started to smoke and kept pushing you to do the same?

____ try one and stop there?

____ start smoking?

____ say no but still hang around with them?

____ stay away from them?

____ talk to your parents about the situation?

____ tell them you snort coke instead?

Give each of your students a copy of the situations, asking them to individually rank order the options, according to what they would do in each case. Form small groups (5 or 6 per group) and provide time for students to discuss their rank orders, sharing the reasons for their choices. Ask each group to determine a group rank order. Bring the class together as one group, so that each small group may report its group rank order to the class. Compare the small group rank orders, and if time permits, develop a total class rank order. Ask students to share their reactions to the situations and the task of making decisions about the options.

THE DYNAMICS OF DISCOVERY

Science

Time Required: Three days to two weeks

Objective: To provide an opportunity for students to examine the historical, scientific, and personal factors which influenced those who have made important scientific contributions.

Method: On an individual or small group basis, ask students to research the work and lives of people such as Mendel, Darwin, Kepler, Copernicus, Galileo, and Mendeleev. Specifically ask students to identify the way in which the work and theories of each ran contrary to popular scientific and/or social opinion. Discuss the personal frustrations of each scientist with reference to Maslow's hierarchy of human needs (Physical, Safety, Love, Self-Worth, and Self-Fulfillment). Ask the students to identify ways in which they must deal with feelings similar to those of the scientists they have studied.

CURRENT UNKNOWNS

Science

Time Required: One to two weeks

Objective: To develop student skills at building an hypothesis and designing a plan for scientific study; to create increased awareness of the political nature of current scientific issues.

Method: In small groups or on an individual basis, ask students to select one of the following research topics: the nature and origin of the universe; effects of pesticides and herbicides; effects of nuclear power; global effects of population growth; cloning and genetic research; strip mining; energy consumption; and undersea oil exploration. Allow students time to gather data, develop an hypothesis, and design a research plan which would test the hypothesis. Ask students to identify both the arguments which would be made against their hypothesis and the groups which would make them. Allow time in class for each individual or small group to present this material and for the class to discuss ways in which the student hypothesis could be defended in light of the attack from outside groups. Ask students to compare their imagined defense of their hypotheses with the experiences of famous scientists in the past.

GUIDELINES FOR PARENTS

ON

ANSWERING QUESTIONS ABOUT DRUGS

Some Suggested Guidelines for Parents on Answering Questions on Drug Related Topics:

Start with a short, simple answer making it easy to add information if it is indicated. Children only process what is meaningful and understandable.

Before answering a question about drugs, make certain you know what the child is really asking.

Try responding to the children's questions about drugs by referring the questions back to them - the "what-do-you-think?" technique.

Encourage children within the family to answer each other's qeustions with your guidance, of course.

Don't be afraid not to answer questions - especially if you aren't sure of the answer, if you feel it is an inappropriate question perhaps about your personal life, it makes you feel very uncomfortable, or if it makes other children in the family feel uncomfortable or is beyond their comprehension. You may wish to go together to seek answers to the "stumpers" from other resource people within the community.

Discuss or answer questions as if it were your child's accurate decision-making process that is at stake.

Remember that as much or more is said by what you don't say. You don't have to be a trained teacher to be an effective drug educator of your children. Honest, straight forwarded responses about your feelings go a long way in making you an askable parent in this area.

Regarding viewing TV programs/movies with drug ramifications, you may want to consider

> Permision - if you (parents) can watch it with them to answer any questions.
>
> Permission with the understanding that, if you (parents) feel it is beyond the child's maturity level, the child agrees to exit gracefully - (no arguments).
>
> Some programs as opportunities between parents and children to discuss morals and values in depth.

Don't put it off. By the time children are big enough to ask, they've picked it up elsewhere. If they don't seem interested or don't ask, they're probably getting their answers somewhere else.

(Suggested Points - cont.)

Ask for help from your church/synagogue, schools or other community agencies. If you think it might enable you to handle discussions with your children more comfortably or adequately. They have articles, materials, and staff that can be immensely helpful. These are excellent sources for bibliographies on various topics, too.

Initiate some self-help groups with other parents with whom you feel comfortable. Take advantage of related programs offered in your community.

Read materials available on issues you and your children might be discussing at appropriate times. This will promote your degree of comfort with various issues (which will be perceived by your children).

Make a commitment to your family's drug education. If it means scheduling it, do so. Sometimes our lives get so hectic we neglect the truly important things like special times and talks together. This might require parents to talk to each other about what they want to teach their child and at what age(s). Unity between parents is important to avoid sending conflicting and/or confusing messages on these issues.

Use appropriate terminology. It helps to encourage children to do so, also, rather than fostering their use of the latest slang for the multitude of drugs.

Get your bids in first. Be the primary drug educators of your children. Then, what they learn at church/synagogue or school can strengthen your stand and the misinformation that they receive from their peers and the media can be discarded by them as just so much garbage unworthy of their attention.

Don't neglect dealing with feelings and remember knowledge encourages understanding, reduces irrational guilt and promotes responsible behavior.

REFLECTIONS

BY

JUDITH A. SZYMALAK

CONCERNED HOMER PARENT

The following is a brief summary of one parent's reaction to the local drug situation based on her attendance at Wyoming Seminary's Schools, Youth, and Substance Abuse training institute from June 29-July 1, 1981. It was donated to this project to be included for schools to use as they see fit.

Our way of living has changed extremely in the last fifty years and because of these changes, we now have societal problems that are getting out of hand. We must not be afraid to come together and admit our problems and work to find viable solutions.

"Transitions of America's Families 1930 to 1978", included in the introductory segment of this manual, gives you an idea of the many significant changes that have occurred within fifty years. They are all contributing factors to our deteriorating society.

How have these changes affected our children? It seems they are now growing up with poor living skills.

Today most kids have a weak identity with a viable role model. They have never seen themselves as a responsible part of the family process. They do not have credible solutions to problems. They have inadequate intra-personal skills - self discipline, self control, self assessment. Also, kids have inadequate inter-personal skills such as listening, feeling and hearing what others are saying. They have inadequate sytemic skills and are unable to handle relationships and situations with responsibility. Lastly, they have poor judgemental skills.

Statistics show the U.S. has the poorest mental health in the world. Our kids mature 7 to 8 years later than those in other countries with life styles similar to ours. The average age in the U.S. of becoming an adult is 24!

In order to bring ourselves to a healthier society we are first going to have to be willing to make changes necessary to give our children these very important living skills.

Teachers are going to have to be willing to incorporate the teaching of these living skills within their curricula. They must be willing to be a teacher of students rather than a teacher of subjects.

In a recent survey in Chicago, 96% of total teaching hours was spent on academics and only 4% was spent on living skills:

One reason why SAT scores have declined is because students lack maturity and communication skills.

In one school (unknown to me) by teaching a curriculum much more slowly but more effectively, students increased their SAT scores by 114% and drastically reduced their absenteeism.

The answer to these problems is not necessarily slicker curricula, but rather better teacher involvement - teachers with a willingness to help mold the complete child.

I hear the echoes of the teachers saying "Those skills should be taught in the home, I have enough problems just teaching academics."

I certainly agree and sympathize with these teachers, but unfortunately I do not see a solution for a healthy society without the help of our schools. I also feel that once they do begin helping the student to build good living skills, their classes will become more enjoyable and very worthwhile and rewarding.

Parents must also be made aware of why the children in the U.S. have the highest rates of violence and crime, suicide, pregnancy, dysfunctionality, alcoholism and drug abuse of children in any other country in the world.

They must also be taught how to develop capable families. Parents need to treat their children with discipline, dignity and respect.

Kids are learning "instant gratification" very early in life and it probably is the most harmful thing a parent can teach a child.

The time factor for parenting is missing. Parents now spend an average of 14 minutes a day in interaction with their children as opposed to 8 hours a day fifty years ago. By the time a child has reached the age of 18, he has spent an average of 18,000-22,000 hours watching TV, spent 12,000 hours at school and 3-4,000 hours with his parents.

Although lifestyles are very different today, parents can still learn to be effective with their children. Parents today are confused and feel guilty for the lack of time they spend with their families. They don't understand why things go wrong. Parents, too, must be recognized for having the most difficult job of all today - raising a child to become a capable human being.

I believe parents are ready to look at ways to effectively raise their children. Such programs as STEP (SystematicTraining for Effective Parenting) would be of help to them.

Our community or schools could provide workshops in parenting skills. Our school newsletter could provide articles for parents on how best to teach living skills.

I'm sure we all agree that something must be done in order to bring us back to a healthy society. We just have to decide that we are going to try. Ignoring it will only make things worse. There is no time to wait for data or proven solutions - that's a cop out. We (meaning parents, school, and community) can come up with a few sensible ways to start tackling the problem.

It all begins with caring. Caring enough to want the best possible world for everyone and setting the goal of providing our children with the very best chance of becoming whole, healthy individuals.

ASSESSMENT
TECHNIQUES AND TOOLS

INTRODUCTION

Assessment of needs is a key factor in an analysis of effective alternatives to drug abuse. This assessment may deal with programs, usage, and viewpoints.

The assessment tools that are available are numerous and multifaceted. There is no "one" correct or proper method for assessing the needs of a given population.

You are encouraged to use what is included in this section for reference to devise more appropriate, localized material. This section can aid you immensely in determining: where you are, where you are going and how well you are doing in getting there. In any case, effective needs assessment is a key factor in providing effective alternatives to drug, alcohol, and tobacco abuse.

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SOURCES

Part A: General Background

I. Preparing for the Needs Assessment in Prevention Planning

- National Institute on Drug Abuse, Vol. II "A Needs Assessment Workbook for Prevention Planning"
  U. S. Department of Health and Human Services
  5600 Fishers Lane
  Rockville, Maryland

II. Needs Assessment Techniques

- National Institute on Drug Abuse, Vol. II "A Needs Assessment Workbook for Prevention Planning"
  U. S. Department of Health and Human Services
  5600 Fishers Lane
  Rockville, Maryland

III. Training and In-Service

- Kay Boniface, Ed.D.

Part B: Specific Assessment Tools

I. A) Delphi Technique

- *Handbook for Effective Supervision of Instruction*
  Neagley/Evans
  Prentice-Hall Inc., 1980

B) Assessing the Need for Curricular Improvement

- *School Administration*
  Richard A. Gerton
  Wm. C. Brown Co., Publishers, 1976

C) Health Attitudinal Survey

- Dippo/Russell
  Cortland City Schools
  Cortland, NY   10345

D) Value Ranking

- Alchol Education - A Teacher's Curriculum-Guide for Grades 7-12
  State Education Department
  Albany, NY 12234

E) Teacher Survey

Cortland City Schools
Cortland, NY 13045

II. A) Community Program Questionnaire

- Alcohol Education for Adults - A Guide for Instructors
  State Education Department
  Albany, NY 12234

B) Alcohol Pre-Test

- Alcohol Education for Adults - A Guide for Instructors
  State Education Department
  Albany, NY 12234

C) Adult Evening Session

- Alcohol Education for Adults - A Guide for Instructors
  State Education Department
  Albany, NY 12234

D) Pre-Test (Medical Hazards)

- Spenco Medical Corp.
  Box 8113
  Waco, Texas 76710

E) Student Opinion Poll

- Alcohol Education - A Teacher's Curriculum Guide for Grades 7-12
  State Education Department
  Albany, NY 12234

F) Drinking Diary

- Drinking Driver Program
  Dept. of Motor Vehicles
  State of New York
  Albany, NY 12234

III. A) Smoking Survey

B) Smoker's vs. Non-Smoker's

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

C) Student Smoking Survey I

American Cancer Society
Cortland, NY 13045

D) Student Smoking Survey II

Cortland City Schools
Cortland, NY 13045

E) Smoking Test

- Public Health Service Publication #1904

F) Pre-Test (Medical Hazards)

- Spenco Medical Corp.
  Box 8113
  Waco, Texas 76710

IV. A) Student/Parent Comparative Survey

- National Clearinghouse for Drug Abuse Information
  Box 1080
  Washington, D.C. 20013

B) Pre-Test (knowledge)

C) Drug Survey

Cortland City Schools
Cortland, NY 13045

D) Assessment of Drug Usage

E) Drug Questionnaire (Tricks or Treats)

- Spanco Medical Corp.
  Box 8113
  Waco, Texas 76710

G) Strategies in Drug Education

Needs Assessment and Substance Abuse Prevention General Background

Summarized from:

National Institute on Drug Abuse, VOL. II "A Needs Assessment Workbook for Prevention Planning"
U.S. Department of Health and Human Services

INTRODUCTION

This section focuses on the needs assessment part of prevention planning. For this purpose, needs assessment can be defined as:
A research and planning activity that seeks to identify the extent and types of existing and potential drug and alcohol abuse problems in a community, the current services available in the community, and the extent of unmet needs or underutilized resources in order to plan appropriate prevention services.

This definition integrates a research activity into a planning process. The results of a needs assessment will have little meaning if they do not lead to program planning! There is no one right way to do a needs assessment. It can be as simple as short interviews with a few school officials or as complex as a massive community survey involving interviews of hundreds of respondents. We should attempt to develop a clear and consistent approach to identifying the problem areas, thereby improving program planning.

Part I: Preparing for the Needs Assessment in Prevention Planning

Although, as already noted, there is no universally recognized model or framework for conducting a needs assessment, there are certain steps in assessment activities that should be taken at the outset, no matter what approach is used. These steps are:

- Identifying the purpose of the needs assessment
- Organizing the effort and assigning responsibilities
- Establishing information requirements for the needs assessment
- Identifying existing data
- Developing the needs assessment plan

Each of the steps is described in the following section:

Step 1: Identifying the Purpose of the Needs Assessment

This careful identification of the purpose of the needs assessment is crucial to the process of planning a study that will be meaningful and useful. At a minimum, identifying the purpose of the needs assessment should:

WORKSHEET FOR STEP 1

In order to conduct a functional needs assessment that purposes must be identified and refined. The goal of this step is to review and place priorities on the goals of your needs assessment so that you can identify a realistic purpose or a set of purposes. Careful planning of this stage will contribute to the development of a meaningful and useful study.

1. Review the list of examples of purposes:

    a. Assesses appropriateness of goals, objectives, and activities.
    b. Plan new goals, objectives, and activities.
    c. Provide guidelines at the school/community level to help programs meet local needs.
    d. Provide accountability information about prevention activities and services.
    e. Identify duplication of services and unmet needs.

2. Brainstorm with the other members of your group in response to the questions: What will we do with the information? Why do we need a needs assessment?

*The following list of specific examples may help you get started.

Check those that apply and add others of your own.

_____ To identify unmet needs.

_____ To identify new target or high-risk populations.

_____ To identify duplication of services.

_____ To provide baseline data for evaluation.

_____ To research the communities perception of the substance abuse problem.

_____ To research the communities perception of the need for services.

_____ To identify barriers to the target population utilization of available services.

_____ To support request for funding.

_____ To support the development of a total plan.

_____ To validate current activities.

_____ To provide accountability data.

_____ To plan new programs.

_____ To identify existing services or produce a directory.

_____ Other: ______________________________________

3. Your needs assessment data collection should be orientated toward assessment of needs, resources, or both. If you are concerned with needs, review these questions.

Your priority is the assessment of:

_____ 1. The school/community needs for prevention services.

_____ 2. The demand for a utilization of prevention services.

_____ 3. Both of the above.

_____ 4. Other (specify): ____

____

____

The goal is to:

_____ 1. Refine the understanding of the target population.

_____ 2. To identify new target populations.

_____ 3. Both of the above.

_____ 4. Other (specify): ____

____

____

4. Review the decisions you made above. From your list of purposes choose the most important ones; refine them if necessary; combine them if you can; and list them by order of priority.

1. ____

____

2. ____

____

3. ____

____

4. ____

____

5. ____

____

5. Identify any additional agenda. Check any that apply from our list of examples and add any others.

____ 1. Involve the local or county preventors in needs assessment.

____ 2. Involve key community leaders in needs assessment.

____ 3. Involve school officials in needs assessment.

____ 4. Establish a dialogue with local prevention program staff.

____ 5. Establish a dialogue with community leaders.

____ 6. Establish a process for doing needs assessment.

____ 7. Other: ______________________________

____

____

Step 2: Organizing the Effort

Before conducting any needs assessment, it is important to organize the effort in a way that will allow for consistent and continual monitoring of activities. Further, if needs assessments are to become an integral part of the planning process, someone in the organization should have permanent responsibility for them. A key person possessing a variety of technical and leadership skills should be carefully selected. The person should:

- Be capable of supervising the entire needs assessment efforts, including conceptualizing and defining needs assessment objectives and tasks.

- Be capable of gaining the cooperation of data sources, monitoring the field operations, supervising field staff, and serving as a liaison among any state agency,involved local school officials, the needs assessment group, and interested parties in the community.

- Have the political clout to ensure that needs assessment results are used by program planners.

An assessment advisory committee or task force can be extremely valuable in needs assessment. Such a committee should be representative of all those interested in prevention programs. The adivsory committee or task force should be involved as early in the needs assessment planning as possible. This will permit input into overall design and objectives, aid in ensuring that the data collected are relevant and useful to planning prevention programs, and exist in meeting the purposes you have set for a needs assessment.

WORKSHEET FOR STEP 1

The following is a worksheet to help in achieving these purposes:

- Define the general area of concern - the target group's.
- Delineate the overall scope of the needs assessment effort - the problem's to be addressed.
- Describe and formulate what is to be achieved - how the information will be used.
- Translate the description into research objectives.

The following four general purposes for conducting needs assessments are presented as illustrations to help you in this step:

1) Purpose: To assess the appropriateness of existing goals, objectives, and activities and to plan new goals, objectives, and activities.

2) Purpose: To provide guidelines at the school/community level in order to help programs meet local needs.

3) Purpose: To provide accountability information about prevention activities and services.

4) Purpose: To identify duplication of services and unmet needs.

WORKSHEET FOR STEP 2

It is important to organize the effort so that responsibility and resources are clearly delineated.

1. Identify a key person ______________________________.

2. Consider the need for an advisory group or consultants.

   - Identify any individuals, groups, or agencies that can contribute resources to provide useful assistance in conducting the needs assessment: ______________________________

     ____

     ____

   - Identify any individuals, groups or agencies that might cooperate in conducting the needs assessment (including those who might share or provide data): ______________________________

     ____

     ____

   - Identify any individuals, groups, or agencies that should "buy in" to your success in implementing the findings of your needs assessment (including those who will be affected by the needs assessment): ____

     ____

     ____

   - Identify any other issues to be considered in selecting a task force or advisory committee or consultant: ______________________________

     ____

     ____

3. List potential advisory group members or consultants. (Note that even if it is not feasible to try to hold formal group meetings, it may be very useful to maintain contact with these members by mail or phone): _____

   ____

   ____

4. What roles can the task force or advisory committee or consultants perform? (For example: open doors, give technical advise, and provide liaison with other agencies). ______________________________

   ____

   ____

Step 3: Establishing Information Requirements

Once you have decided the purpose of the needs assessment and a list of questions has been generated, the next step is to specify the information that answers the questions.

WORKSHEET FOR STEP 3

The purpose of the needs assessment must be translated into the precise kind of information you want to obtain and from whom.

1. Review the purposes you identified.
2. In order to achieve these purposes you must answer some questions.

   Identify the questions you must answer and the data which will be required to provide these answers.

Research Questions	Data Requirements
Examples:	Examples:
Purpose:	
To justify the need for prevention services in the target population.	
Questions:	
Demographically, what does the target population look like?	Age, race, sex, employment status, education status.
What sort of substance abuse problems occur in the target population? Is there a problem?	Substances being abused; frequency of abuse.
Which are the high risk groups within the target population? What are the demographic and social-psychological correlators?	Demographic characteristics, social-psychological characteristics (such as self-esteem scores) and data on whether there is a substance abuse problem.
What services would be meaningful?	Opinions; research literature.

Step 4: Identifying Existing Data

Once you have identified your data requirements, the next step is to determine where the data can be found. In securing data, the following are some of the agencies, institutions, or publications that may be helpful:

- U.S. Census Bureau Reports
- Federal and State clearinghouse for drugs and mental health information.
- Bureau of Labor Statistics reports, Department of Labor
- Federations of social and/or health organizations.
- City, county, and state planning departments.
- City and county health, welfare, and vocational rehabilitation agencies.
- City and county mental health agencies.
- City and county courts and law enforcement agencies.
- Local and state chambers of commerce.
- Colleges and universities.
- State departments of education.
- State departments of health.
- Local mental health, drug, alcohol, and other prevention-related programs.

This list is not exhaustive, but it represents some of the primary sources of statewide and community based data. Although accruing data from these sources may initially be time-consuming, in the long run they may save you effort by providing data you do not have to generate yourself. Also, in developing contacts with these agencies, you can create a continuous flow of information and develop collaborative planning relationships.

WORKSHEET FOR STEP 4

Review the list of data sources and identify in the right hand column any data elements from these sources which might fulfill some of your requirements (as identified in Step 3). Add any others which are potentially useful.

Existing Data Sources	Data Elements
- U.S. Census	Example: Age, sex, race, marital status, educational status.
- National Center for Health Statistics	
- National Institute of Mental Health	
- Professional associations	
- City, county, and state planning departments	
- Mental Health centers	
- Law enforcement agencies	
- Chambers of Commerce	
- State Departments of Health and Mental Health	
- State Departments of Education	
- Other: ____________________	
______________________________	

Step 5: Developing a Needs Assessment Workplan

The last step in preparing for the needs assessment is to establish a workplan that identifies and gives details of the needs assessment activities. The purpose of the plan is to describe step-by-step the procedures that will be followed in conducting the assessment. A plan should cover the following list of activities:

- Estimating costs and resources
- Selecting data collection techniques
- Designing data collection instruments
- Planning for data processing
- Establishing data collection controls
- Deciding on methods of analysis
- Scheduling activities
- Collecting Data

WORKSHEET FOR STEP 5

The needs assessment workplan should describe step-by-step the activities that will be involved in conducting the needs assessment. It should contain a schedule for the timing of these activities.

Example:

Activities	Time Frame	Person Days
Design Project	1.5 weeks	7
Plan Tasks	2.5 weeks	8
Develop instruments	3.5 weeks	10
Collect data	3.0 weeks	22
Analyze data	2.0 weeks	12
Report results	1.0 weeks	11

Part II: Needs Assessment Techniques

The three most used needs assessment techniques will be listed. Each agency or planning group will have to choose from these needs assessment techniques, and in doing so, a variety of factors should be considered: the availability of staff and consultant resources, time requirements, cost, range of complexity, degree of sophistication, the target population to be investigated, and environmental conditions and constraints.

Technique 1: Key Informant

Description:

The key informant technique is essentially a survey of knowledgeable people such as police, clergy, clinic directors, school officials, and program clients, asking about their perceptions of the nature and extent of the existing or potential drug and alcohol abuse or related problems in the community.

Purpose:

The survey is an effort to locate and identify the at-risk populations and to define the need for prevention services among those populations.

Steps in Implementation:

1. Describe the goals and objectives of the assessment.
2. Develop criteria for selection of key informants
3. Identify the key informants
4. Develop a data collection methodology
5. Construct the instrument or interviewer's guide.
6. Select and train interviewers.
7. Contact respondents and schedule interviews
8. Interview the respondents to collect the data
9. Analyze the data

WORKSHEET FOR KEY INFORMANT TECHNIQUE

1. List your purposes in using this technique. ______________________

____

2. List any issues and assumptions you will need to consider in using this technique.

Example: Assume that the informants have some sort of contact with target population and that the informants are relatively objective in their observations.

____

____

____

3. In light of these issues, considerations and assumptions, what steps should you take to protect the validity of your data?

Example: Choose a relatively large number of informants with highly varied backgrounds.

____

____

____

4. What criteria will be used for selecting the key informants?

Example: The type of informants might include professionals from social service agencies, community leaders, individuals in the target population.

____

____

____

5. How will key informants be identified?

____

____

____

6. How will the data be collected?

Method: ____.

Examples: Face-to-face interview, telephone interview, group interview, mail-out survey, Delphi group technique.

____

____

____

Structure: ____.

Example: Structured with instrument, structured with interviewer's guide.

____

____

____

Type of Questions: ____.

Examples: Open-ended or forced choice.

____

____

____

7. How will you follow-up, give feedback, and use the data?

____

____

____

Technique 2: Community Survey

Description:

An interview or self administered questionnaire is used to collect data on sociodemographic characteristics, problems and needs, and knowledge about and attitudes towards substance abuse and substance abuse prevention services in the target populations or in the community.

Purpose:

This technique attempts to locate and refine the identification of the trageted populations and high-risk populations, and to identify their needs and the most effective means for reaching those populations.

Steps in Implementation:

1. Describe the goals and objectives of the assessment
2. Define carefully the targeted populations
3. Develop criteria for sampling
4. Construct the instrument
5. Collect the data
6. Analyze the data

Worksheet for Community Survey

1. List your propose's in using this technique.

2. List any issues, considerations, and assumptions you will need to consider in using this technique.

3. Define your target population.

4. Develop criteria and methodology for sampling.

   Sampling techniques: ____.

   Examples: Random sampling, selected sample.

   Sample size: ____.

   Sampling approach: ____.

   Examples: Area sampling, list sampling.

5. How will you follow-up, give feedback, and use the data?

Technique 3: Demographic Analysis

Description:

Demographic analysis uses data from sources such as the Census Bureau, the Department of Labor Statistics, and vital statistics from a variety of other agencies to make projections about the target populations.

Purpose:

Demographic analysis attempts to identify the target populations and project their needs.

Steps in Implementation:

1. Describe the goals and objectives of the assessment
2. Define the types of data needed
3. Contact local, state, and federal agencies to determine what data are available
4. Access the data
5. Analyze the data

WORKSHEET FOR DEMOGRAPHIC ANALYSIS

1. List your purpose's is using this technique.

2. List any issues, considerations, and assumptions you will need to consider in using this technique.

3. In light of these issues, considerations, and assumptions, what steps should you take to protect the validity of the data?

   Example:

   Dates when the data was collected and subsequent population shifts that might undermine data quality should be examined.

4. How will you determine what data is available?

5. How will you follow-up, give feedback, and use the data?

Part B

SPECIFIC ASSESSMENT TOOLS

Identification of specific local concerns related to alcohol, tobacco, and general drug use/abuse is necessary in order to facilitate effective and "on target programming". Several examples of methodology related to needs assessment will follow. The aim of the examples in this section is to determine the local needs of parents, teachers, and students related to the area of substance abuse. It is hoped that this will serve as a methodology for creative and effective programming for parents, teachers, and students.

The rest of this section takes a look at needs assessment tools related to substance abuse. You may use these tools, adapt them or develop your own.

I. Needs Assessment

Substance Abuse Education

Adults (Parents/Teachers)

Example A: The Delphi Technique (Adaptable to many domains)

Over the years much has been written about the importance of group discussion to solving educational problems. Group dynamics has become a password, and decision making by consensus has been favored over voting and majority decisions.

The Delphi Technique is a method of assessing group opinion by individuals through responses to a series of group meetings. This approach provides an organization with an objective means to:

1) assess the range of ideas about goals and objectives.

2) give priority ranking to these goals and objectives.

3) establish the degree of consensus about the goals and objectives.

The Delphi procedure may be described as follows:

1. Participants (who may remain anonymous to one another) are asked to list their opinion on a specific topic in the form of brief written statements to prepared questionnaires such as recommended activities or predictions for the future.

2. Participants are then asked to evaluate their total listing against some criterion, such as importance, chance of success, etc.

3. Next the statements made by the participants are received and are clarified by the investigator.

4. Each participant then receives the refined list and a summary of responses to the items and, and if in the minority, is asked to revise his opinion or to indicate his reason(s) for remaining in the minority.

5. The statements made by the participants are again received by the investigator who further classifies, refines, and summarizes the responses.

6. Each participant then receives the further refined topical list which includes both an updated summary of responses and a summary of minority opinions. Each participant is also given a final chance to revise his opinions.

7. Finally, the investigator receives the last round of the questionnaires which he then summarizes in a final report. The successive, individual and independent process of requestioning of each of the experts (participants), combined with feedback supplied separately from each of the other participants, is designed to eliminate misinterpretations of the questions and the feedback, and to bring to light knowledge available to one of a few members of the group but not to all of them.

Sample Delphi Technique (using group of 20 participants)

Step 1

1) What are the most important health related problems which you believe impair your effectiveness as a parent (teacher)?

Results: drug usage
alcohol usage
improper hygiene
tobacco usage (smoking & chewing)
pre-marital sex
communicable disease

2) List the problems you have identified by order of urgency.

Results: #1 alcohol usage
#2 pre-marital sex
#3 drug usage

Step 2

Enclosed are the results of our initial survey question concerning health related problems. The 3 areas identified by most participants as the major problems are:

- alcohol usage
- drug usage
- pre-marital sex

If you did not initially agree with one or more of these areas as a major problem you may change your opinion. If you cannot change your opinion, please indicate your reason(s) for your views.

Please choose what you believe to be the major health related problem, from the following choices, which you believe impairs your effectiveness as a parent (teacher).

- alcohol usage
- pre-marital sex
- drug usage
- other ______________________

Remarks: 1) 3) 5)

2) 4) 6)

Step 3

Enclosed are the results of the latest survey identifying the major health related problem as viewed by our participants. The results are:

#1	alcohol usage	(14)
#2	pre-marital sex	(2)
#3	drug usage	(2)
#4	tobacco usage	(1)
#5	communicable disease	(1)

Selected comments:

1)
2)
3)
4)
5)
6)

Alcohol usage is identified as the major health related problem which impairs our group's effectiveness as parents (teachers) - (Enclosed select comments).

Example B: Evaluative Criteria for Assessing the need for Curricular Improvement

The following list of questions will help give an individual a basis for looking at curricular improvement. Can be given to Parent-Teachers.

1) Has the school established clearly stated, operationally-defined, educational objectives?

2) Are the courses in the curriculum helping to achieve school objectives?

3) Does the curriculum meet the needs of all students? Is it comprehensive?

4) Does the curriculum reflect the needs and expectations of society, as well as the needs of the students?

5) Does the content of the curriculum provide for the development of student attitudes and values, as well as knowledge and skills?

6) Are the curriculum materials appropriate for the interests and abilities of the students?

7) Are the educational objectives for each subject in the curriculum clearly stated and operationally defined?

8) Are the various subjects in the school curriculum achieving their proposed objectives?

9) Is there subject matter articulation between grade levels, and correlation among the various subjects of the curriculum?

Example C: Health Attitudinal Survey - (Adults-Secondary)

Below, you will find statements pertaining to various areas of chemical abuse. Please be honest and sincere in giving your first reaction to each statement. Since this is not a test and will not be graded, these reactions should express your True feelings.

The numbers are coded as follows:

1 - Strong Agreement	2 - Mild Agreement	3 - Mild Disagreement	4 - Strong Disagreement

Directions: Read each statement carefully. Next to the corresponding number on the answer sheet, in pencil, circle the number which indicates your degree of agreement or disagreement with each statement. If you change your mind, erase your first mark completely.

1. There is no risk in smoking as long as you don't inhale.

2. It is senseless for an habitual smoker to quit because the damage has already been done.

3. The human and monetary costs of cigarette smoking outweigh the value found in the habit.

4. A non-smoker should not condemn those around him who do smoke.

5. The simplest way to avoid the consequences of smoking is to avoid that first puff.

6. A person should consider the facts available before making a decision about smoking.

7. The evidence against smoking is statistical and, therefore, is inconclusive.

8. The appeal of alcohol tends to increase in proportion to the immaturity of the individual.

9. At a party where beer and cocktails are served, a guest is expected to drink alcoholic beverages.

10. A respectable family background, a good education, and success in business will keep a social drinker from becoming an alcoholic.

11. Alcoholism is far from being strictly a personal problem.

12. A good host relies on cocktails to create a pleasant atmosphere.

13. Alcoholics should be considered criminals and should be treated as such.

14. A person should not pressure others to drink.

15. Drinking should be the main purpose for having a party.

16. People function better intellectually and artistically under the influence of hallucinogenus such as LSD.

17. A person is "chicken" if he refuses to try a drug on a dare or challenge.

18. The circumstances under which marijuana is smoked are often conducive to experimentation with other drugs.

19. Judicious (wise) use of drugs by the individual is society's best protection against drug abuse.

20. The hallucinogenic drug user's ability to evaluate his experience is inaccurate and unreliable.

21. An addict is a criminal who should be put in jail and made to kick the habit without gradual withdrawal.

22. Rehabilitation of drug addicts has been extremely successful.

23. A drug addict released after treatment should go back to his usual pre-hospital environment for the security provided by familiar surroundings.

24. A drug may be bought without a prescription if it has been proven to be safe and effective for most people when taken according to instructions.

25. The safety of all new drugs should be determined before the public uses them.

HEALTH ATITUDIANL SURVEY

Answer Sheet

Age: ____________

Sex: M F ____

Date: ____________

1 - Strong Agreement

2 - Mild Agreement

3 - Mild Disagreement

4 - Strong Disagreement

1. 1 2 3 4
2. 1 2 3 4
3. 1 2 3 4
4. 1 2 3 4
5. 1 2 3 4
6. 1 2 3 4
7. 1 2 3 4
8. 1 2 3 4
9. 1 2 3 4
10. 1 2 3 4
11. 1 2 3 4
12. 1 2 3 4
13. 1 2 3 4
14. 1 2 3 4
15. 1 2 3 4
16. 1 2 3 4
17. 1 2 3 4
18. 1 2 3 4
19. 1 2 3 4
20. 1 2 3 4
21. 1 2 3 4
22. 1 2 3 4
23. 1 2 3 4
24. 1 2 3 4
25. 1 2 3 4

Example D: Value Ranking - The strategy of value ranking allows participants the opportunity to look at priorities, the things they feel are important to them at a point in their lives. Value ranking helps the students place value choices into perspective with the available alternatives.

When using a value ranking list, the participants should rank their own choices from their own set of priorities, which are obviously based upon what they know to be true and reasonable for their own lives. No absolute right or wrong rankings exist for everyone, only for each individual. In essence, what the participants rank are not the three to five items of each statement, but rather life values based on previous knowledge, experience, fears, superstitions, etc.

This system will help to assess the values of a given population (parents, teachers, students) and thus determine educational needs of such a group. This may help you establish your boundaries for effective programming.

Value Ranking on Chemical Substances

Directions:

After reading and thinking about the following items indicate your thoughts and feelings about the five choices by ranking each choice a 1, 2, 3, 4, or 5.

Example:

Look at the first ranking item. If after considering the five choices, you felt that cigarettes were most harmful to your physical health, you would rank cigarettes as number 1. If you felt that caffiene was the least harmful of the five choices, you would rank caffiene number 5. The remaining choices would be ranked 2, 3, or 4 depending upon your feelings about them.

1. Rank from 1-5 the drugs which you feel are the most harmful to your physical health.

__________ cigarettes

__________ marijuana

__________ alcohol

__________ aspirin

__________ caffeine

2. Rerank from 1-5 the drugs which you feel are the most harmful to your mental / emotional health. If there is a difference in the way you ranked questions #1 and #2, explain.

__________ cigarettes   Explain difference: ______________________

__________ marijuana   ____

__________ alcohol   ____

__________ aspirin   ____

__________ caffeine

3. Rerank from 1-5 the drugs which you feel would give you the most satisfaction/ pleasure when used.

__________ cigarettes

__________ marijuana

__________ alcohol

__________ aspirin

__________ caffeine

4. Rank from 1-5 the person you feel is most in need of help.

__________ speed freak

__________ alcoholic

__________ pot head

__________ smoker

__________ heroin addict

5. Rank from 1-5 which pattern of use you feel is the most harmful to your health over long periods of continual use.

__________ coffee

__________ tea

__________ cola drinks

__________ chocolate

__________ aspirin compounds/headache remedies

7. Rank from 1-5 why you think most people overuse or abuse drugs.

__________ conditioning to a drug culture

__________ escape

__________ ignorance

__________ peer pressure

__________ thrill seeking

8. Rank from 1-5 those persons you would most like legal action taken against.

__________ alcoholic

__________ person who is intoxicated while driving an automobile

__________ drug addict

__________ illegal drug importer/manufacturer

__________ M.D.'s who prescribe drugs unnecessarily

9. Suppose you know a drug pusher. Rank from 1-5 how you feel you would react.

_________ keep the information to yourself

_________ notify legal authorities

_________ tell your friends

_________ tell your relatives

_________ blackmail him

10. Rank from 1-5 your greatest source of drug education up to the present time.

_________ literature

_________ school

_________ home and church

_________ friends and peers

_________ electronic news media

11. Rank from 1-5 the commercial advertisements you find most despicable.

_________ aspirin/pain relievers

_________ sleeping products

_________ weight control products

_________ antacids

_________ cough relief/suppressant products

12. Rerank from 1-5 the frequency you use the products in #11. Is there any relationship between your rankings of #11 and #12?

_________ aspirin/pain relievers

_________ sleeping products

_________ weight control products

_________ antacids

_________ cough relief/suppressant products

Relationship: ____

____

____

____

Example E: Teacher Survey

The questions listed below may be used to determine some basic reactions and opinions of the teaching staff related to drug abuse. A slight change in wording (as noted by parentheses) makes the questions applicable for all areas of drug abuse. Anonymity should be upheld.

1. What is your opinion toward marijuana (alcohol, tobacco, drugs)?

2. Do you think any of your students come to class "high" ("drunk")?

3. What do you think the faculty can do to prevent the drug problem?

4. What action is being taken if a student is known to be using drugs?

5. Where and how are students obtaining drugs?

6. Why do students take drugs?

7. Would you like to add any questions?

You may think of questions that may be more relevant to your particular local situation.

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II. Needs Assessment

Alcohol Education

Adults (Parebts/Teachers)

Example A: The program which will be developed in this sample will attempt to meet the needs of a large group of concerned parents in a school district. The parents have become increasingly alarmed over the growing use of alcohol by teenagers in the community. A representative has contacted the principal (superintendent) for the school district and spoken of the concerns of the community.

At this point, the Superintendent can begin to develop a program which meets the needs of the parents. The contact person has indicated that the program should be completed in one session. Area specialists in the field of alcohol prevention and rehabilitation are invited to participate in the program. Contacts are made with Alcoholic Anonymous, local hospitals and churches, the Department of Mental Hygiene, and rehabilitation centers to find the most appropriate and qualifed persons for the program. Once the format, in this case group presentation and question and answer period, has been decided upon, the speakers contacted, and the time and place determined, the Superintendent can concentrate on publicity for the program. Next, an evaluative form of some kind will be developed to assess the relative success of the program. A sample questionnaire is inlcuded on the following page.

SAMPLE QUESTIONNAIRE

Dear Concerned Citizen:

In order to better serve our community, and to respond to the needs of the residents, it would assist us greatly if you would complete the following questionnaire this evening and return it before you leave.

The results of this survey will aid us in planning future programs.

Thank you for your cooperation,

Superintendent

1. Were you aware of an alcohol problem in our community prior to this program? YES ________ NO ________
2. If your answer to the previous question was YES, did you think the problem was as critical as described this evening?

   I THOUGHT IT WAS WORSE. ________

   I DIDN'T REALIZE IT WAS SO BAD. ________
3. Were the guest speakers informative? YES ________ NO ________
4. Did you find that the question and answer period served the purpose for which it was intended?

   a) Promoted dialogue between youth and adults.

   YES ________ NO ________

   b) Informative as far as the scope of the alcohol problem in our community.

   YES ________ NO ________

   c) Informative as far as the dangerous effects of extensive use of alcohol

   YES ________ NO ________

   d) Provided insight as to why our teenagers are turning to alcohol.

   YES ________ NO ________
5. As a result of this program, would you be better able to handle a problem if one developed in your household?

   YES ________ NO ________

6. Would a follow-up program dealing with the problem of alcohol use be useful?

YES __________ NO __________

7. Do you think a program of this type would be useful in dealing with other problems in our community?

YES __________ NO __________

The evening of this program, the Superintendent (Principal) should be prepared to:

1) Introduce the topic and format

2) Introduce the speakers

3) Provide guidance when necessary through the formal and informal portions of the program.

4) See that the questionnaires are passed out, answered, and returned for assessment.

Upon receipt of the questionnaires, the Superintendent/Principal should evaluate the success of the program and determine the necessity for follow-up programs.

Example B

Any community based adult work group on the topic of alcohol abuse can be pre- and post- tested to identify knowledge, skills, and attitudes which the participants already have. This is also used to determine if the intended learning outcomes have been achieved. An example of such a test is included below. It is intended for use as a pre-test but, the same format can be used to develop a post-test.

Pre-test in the study of Alcohol

Directions: Place a "T" in front of the true statements, and an "F" in front of the false statements.

T 1. Alcohol is a chemical compound consisting of carbon, hydrogen, and oxygen.

F 2. Alcohol raises body temperature.

T 3. The absorption of alcohol usually takes place in the stomach and small intestine.

T 4. The word "proof" designates the level of alcohol found in distilled liquors.

T 5. One factor which determines the rate of oxidation of alcohol is the weight of the drinker.

T 6. A person who cannot control his drinking may be considered by many to be an alcoholic.

T 7. Alcoholism is a disease and should be treated as such.

F 8. One drink makes you an alcoholic.

F 9. The alcoholic always drinks alone, never in public.

T 10. People who drink to excess usually cannot remember what they have done while under the influence of alcohol.

T 11. Emotional stress causes some people to drink.

T 12. People who drink may become violent when they are drunk.

T 13. Alcohol, even in relatively small amounts, affects one's inhibitions.

F 14. Alcoholics are found only in the lower class of society.

F 15. All churches consider drinking of any kind to be sinful.

F 16. It is considered "bad manners" not to drink at social gatherings if drinks are being served.

T 17. Many people drink to feel that they "belong".

F 18. A person who is physically active while drinking will never get drunk.

F 19. Alcoholic beverages are a good form of food.

F 20. People who drink alcoholic beverages do not make good parents.

T 21. For many people, eating when they drink may keep them from becoming intoxicated as quickly as people who drink on an empty stomach.

F 22. Many persons can increase their skill in operating a car by drinking alcohol.

T 23. Various attitudes toward serving and drinking alcoholic beverages are found among different groups in our society.

F 24. It is rather easy to distinguish the alcoholic from the rest of the drinking population.

F 25. If an intoxicated person drinks several cups of black coffee, she/he will sober up rather quickly.

T 26. Taking tranquilizers or sleeping pills while you have alcohol in your system can be dangerous or even fatal.

*The answers have been inserted here for your convenience in making an answer key.

Example C

This program is designed for a one evening - three hour session, recommended for about 30 adults, for discussion of problems that arise with the social use of alcohol.

It is suggested that the evening be planned in a "cocktail-like atmosphere" (no alcohol). Two punch bowls, one containing a large toy spike and the other plain, aid in representing choices to the participants. Chips, dip, cheese, crackers, etc. might also be available.

The topics listed below can be used to identify problems associated with adult social drinking and create awareness to potential problems! They also may help clarify parental views toward alcohol and its use and abuse! Suggested topics might include:

1) The Plan for a Party

   A) Type of beverages, what and how much do you buy? How many shots in a bottle?

   B) Kind of drinks that should be served? One kind or more? Why do people prefer other drinks, cocktails vs. punch vs. wine?

   C) Why should food be available? What types are best ?

   D) What are the advantages and disadvantages of having a cocktail party at a private home, than driving to a restaurant for dinner?

   E) How to start a cocktail party?

   F) How to end a cocktail party?

2. Discuss being the host and offering non-alcoholic beverages

   A) How would you feel about it?

   B) What would you offer?

   C) How would you offer the choice to the guest?

   D) How would you react to an old friend who would criticize you for having non-alcoholic drinks?

   E) How would you react to the guest that always had drank, was the life of the party, and when offered the non-alcoholic drink, accepted it?

3. Discuss being the guest at a party and asking for a soft drink

   A) What pressures are applied to such a person to get him/her to drink alcohol?

   B) Suggest ways she/he may respond to pressures?

   C) Should you go to parties if you know alcohol will be served?

   D) Should a job require one to drink alcohol?

4. What do you do with the guest who has drank too much and still wants to drive home?

   A) What is your responsibility as:

      1. Host or hostess?

      2. Best friend?

      3. Spouse?

      4. Neighbor?

   B) What alternatives are there for people to follow?

5. What do you do with the guest who has drank too much and becomes obnoxious?

   A) What is your responsibility as:

      1. Host or hostess?

      2. Best friend?

      3. Spouse?

      4. Neighbor?

This would be most effective with group discussion under professional supervision.

Example D: Pre-Test related to the Medical Hazards of Alcoholism.

This test, and the related statements, will assess the knowledge of a given group related to the medical hazards of alcohol and help to delineate future programming needs and curriculum direction.

Deals with adult misconceptions.

Direction: Place a "T" in front of the True statements; Place an "F" in front of the False statements. *

T 1. Alcoholics have a far greater chance of developing cancer of the espohagus then do non-alcoholics.

T 2. No ulcer patient should drink.

F 3. In alcholic hepatitis, the liver is generally small, soft and reddended.

F 4. Cirrhosis is the twelfth leading cause of death in America.
(7th cause)

F 5. Delirium tremens begins with tremors, sweating, and nausea, and progresses to confusion and hallucinations, but this problem is rarely fatal.
(Fatal 10% of time)

F 6. Alcohol is a sexual stimulant.
(causes impotence)

T 7. Babies born to alcoholic mothers are often mal-developed, with a brain less than normal size.

T 8. Suicide is the third leading cause of death below age 30.

T 9. Murder is the fourth leading cause of death below age 30.

F 10. Approximately one in every 500 American children is physically and psychologically severely abused at least once.
(1/100)

Copies of this test may be obtained from:

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

*Answers have been given for each statement for your convenience in making an answer key.

Example E: Opinion Poll - An opinion poll could be used as an introduction to the subject area and will give the instructor some ideas of the knowledge and misconceptions that the participants have and will, therefore, will guide the approach to the subject. This is a form of self testing.

Directions: Check those statements with which you agree or which you believe to be true.*

F 1. Alcohol is a stimulant.

T 2. Misuse of alcohol is a major problem in the United States.

T 3. Most teenagers try alcoholic beverages although it is illegal for those under 18.

T 4. Alcohol is a depressant.

T 5. Drinking and driving are not compatible.

T 6. Alcoholism is a disease.

T 7. One 12 oz. bottle of beer contains about as much alcohol as an ounce of whiskey.

F 8. The effect of alcohol on the body is determined only by the amount consumed.

T 9. Beverage alcohol is a source of calories.

F 10. The size of the individual has no relationship to the effect of alcohol on that person.

F 11. 90 proof whiskey means it contains 90 percent alcohol by volume.

T 12. In general, it can be stated that drinking alcohol lowers a person's inhibitions.

F 13. Only about half the people of legal age in the United States use beverage alcohol.

T 14. Only a small percentage of drinkers become alcoholics.

T 15. Certain studies indicate that alcoholism can be hereditary.

*Answers have been given for each statement for your convenience in making an answer key.

EXAMPLE F

DRINKING DIARY

Complete the following chart by keeping an accurate record of the number of drinks you have and the times that drinking actually occurs during a one week period. Since the diary will remain personal and will only be shared with your instructor, please be honest and sincere in its completion. That means - no omitting or exaggerating the number of drinks recorded!!!

The following coding system can be used in recording the type of beverage consumed at the various times during the week:

B=Beer
W=Wine
L=Liquor

EXAMPLE: On the chart you might record - 3B on Saturday from 9-10:30 p.m.

After keeping your record for a week, look at your pattern of drinking and compare it to the patterns on the last page. When does most of your drinking occur? Explain why on the back of this sheet which you will hand in with the chart below. Under which classification on page 2 would you place yourself? Why?

Complete the following statement: "I have learned that my drinking..."

****

		Lunchtime		Afternoon		Dinnertime		Evening	
MON.	Time	From	To	From	To	From	To	From	To
	Drinks								
TUE.	Time	From	To	From	To	From	To	From	To
	Drinks								
WED.	Time	From	To	From	To	From	To	From	To
	Drinks								
THUR.	Time	From	To	From	To	From	To	From	To
	Drinks								
FRI.	Time	From	To	From	To	From	To	From	To
	Drinks								
SAT.	Time	From	To	From	To	From	To	From	To
	Drinks								
SUN.	Time	From	To	From	To	From	To	From	To
	Drinks								

B - Beer
W - Wine
L - Liquor

SUN	MON	TUES	WED	TH	FRI	SAT	
X			X			X X	SOCIAL
X X		X	X		X X	X X	OCCASIONAL - TO RELIEVE TENSIONS
X X	X X	X X	X	X X	X X	X X X	REGULAR - DAILY
X X X X	X X X	X X	X X	X X X	X X	X X X X	RELIANCE TO FUNCTION
X X X X X X	X X X X	X X X X X X	X X X X	X X X X X X	X X X X X	X X X X X X	HEAVY DEPENDENCE

III. Needs Assessment

Tobacco Education

Adults (Parents-Teacher)

Example A: Smoking Survey - This smoking survey can be used for surveying adults or students. It can be used to assess the scope of the localized tobacco problem and several key factors contributing to the problem. From the results, data can be collected and applied to effective educational programming.

1. If you smoke cigarettes, check those statements which best describe your smoking habits and attitudes:

_____ I've smoked cigarettes a few times, but I don't smoke now.

_____ I used to smoke cigarettes, but I don't smoke them now.

_____ I smoke cigarettes once in a while, but not every week.

_____ I smoke cigarettes every week.

_____ I smoke cigarettes every day.

2. How much do you smoke?

_____ Less than one pack a week.

_____ About 2-3 packs a week.

_____ About 3 packs a week.

_____ About 1/2 pack a day.

_____ About a pack a day.

_____ About two packs a day.

_____ More than two packs a day.

3. How long have you been smoking?

_____ Less than a month.

_____ Less than 6 months.

_____ Less than a year.

_____ Less than two years.

_____ More than two years.

4. Why did you start smoking?

_____ Because I wanted to see what it was like.

_____ Because someone offered me a cigarette.

_____ Because my friends smoked.

_____ Other reason - please explain: ______________________________

____

5. Check those times when you usually smoke. You may check more than one statement.

_____ When I am by myself.

_____ When I am studying or listening to music.

_____ When I am with my friends.

_____ When I am at a party.

_____ When I am with my family.

_____ When I am nervous and want to relax.

_____ When I am finished eating.

_____ Between classes.

_____ Other times, please explain: ______________________________

____

6. How concerned are you about the harmful effects of cigarette smoking on your health?

_____ I'm not really concerned about it.

_____ I have a slight concern.

_____ I am concerned.

_____ I am very concerned.

7. Do you think you will be a cigarette smoker five years from now?

_____ Yes, for sure.

_____ Yes, probably.

_____ No, probably.

_____ No, for sure

_____ I don't really know.

Father		Mother
_____	Doesn't smoke cigarettes	_____
_____	Used to smoke, but gave it up	_____
_____	Smokes occasionally	_____
_____	Smokes about a pack a day	_____
_____	Smokes between 1-2 packs a day	_____
_____	Smokes over two packs a day	_____

Example B: Questionnaire Sheet - Smokers vs. Non-Smokers

After placing all the data on the tally sheet the following questionnaire will help to:

1) identify a smoking problem
2) establish related attitudes
3) identify personal goals
4) establish opinions on basic health facts
5) identify the scope of tobacco use and related information for a given group
6) help to identify proper programming procedures needed for specific groups.

Directions: This questionnaire is to be completed in private and kept anonymous. Do not sign this sheet. Results from questionnaire sheets will be tabulated and you will be given a copy of the results. Answer each question as directly as possible by circling the best answer.

* I am a ...

(A) Smoker (B) Non-smoker

I. Background

1. Are you ...

   (A) Male (B) Female

2. Do at least one of your parents smoke?

   (A) Yes (B) No

3. Were (are) your parents divorced?

   (A) Yes (B) No

4. Do approximately half of your friends smoke?

   (A) Yes (B) No

5. Do you have a husband or wife (boyfriend or girlfriend) who smokes?

   (A) Yes (B) No

6. Do you attend church regularly (at least once a month)?

(A) Yes (B) No

7. Do you have at least one son or daughter who smokes regularly?

(A) Yes (B) No

II. Attitudes

1. Do you participate in a hobby regularly?

(A) Yes (B) No

2. In school, did you make mostly

(A) A's & B's (B) C's & D's

3. Did you "hate school"?

(A) Yes (B) No

4. Do you drink alcoholic beverages regularly (at least once a week)?

(A) Yes (B) No

5. Do you feel there is too much regulation in people's lives in America?

(A) Yes (B) No

6. Do you smoke marijuana regularly (at least once a month)?

(A) Yes (B) No

7. Have you ever been drunk with alcohol?

(A) Yes (B) No

III. Personal Goals

1. Did you attend college?

(A) Yes (B) No

2. Do you have your own business?

(A) Yes (B) No

3. Do you (would you) care if your own children smoke?

(A) Yes (B) No

4. Do you worry more about the future than the present?

(A) Yes (B) No

5. Did you wait until marriage to have sex?

(A) Yes (B) No

6. Did you enter a health profession, such as medicine or nursing?

(A) Yes (B) No

7. Do you plan to live beyond age 70?

(A) Yes (B) No

IV. Health Facts

1. Do you believe women run less risk from smoking than men?

(A) Yes (B) No

2. Do you believe air pollution is as harmful as smoking?

(A) Yes (B) No

3. Do you believe it is safe to wait to stop smoking until symptoms appear?

(A) Yes (B) No

4. Do you believe smoking is harmful to a pregnant woman's unborn child?

(A) Yes (B) No

5. Do you believe low tar cigarettes eliminate risks of smoking?

(A) Yes (B) No

6. Do you believe cancer and heart disease are the only real risks from smoking?

(A) Yes (B) No

7. Do you believe X-rays will effectively diagnose early lung cancer?

(A) Yes (B) No

8. Do you beleive non-smokers are physically harmed by smoker's air pollution?

(A) Yes (B) No

Copies of this questionnaire may be obtained from:

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

Tally Sheet for Smokers vs. Non-Smokers

Directions: When questionnaire sheets have all been completed, tabulate the totals for each of the questions on the 4 different panels by totaling the different answers on this Tally Sheet. Use only percentages of YES answers for smokers and percentages of YES answers for Non-smokers for making graphs for display panels.

				Smokers	Non-smokers
I.	Backgrounds				
1.	Sex	Male	____	____	____
		Female	____	____	____

			YES	NO	YES	NO
2.	Smoking Parent		____	____	____	____
3.	Divorced Parents		____	____	____	____
4.	Smoking friends - 50%		____	____	____	____
5.	Husband or Wife (boyfriend/girlfriend) smoker		____	____	____	____
6.	Attend church (at least once a month)		____	____	____	____
7.	Smoking Son/Daughter		____	____	____	____
II.	Attitudes					
1.	Participate in a hobby regularly?		____	____	____	____
2.	Grades:	A's and B's	____	____	____	____
		C's and D's	____	____	____	____
3.	"Hate School"		____	____	____	____
4.	Drink alcoholic beverage once a week		____	____	____	____
5.	Too much life regulation in America		____	____	____	____
6.	Smoke marijuana regularly		____	____	____	____
7	Ever drunk on alcohol		____	____	____	____

III. Personal Goals

		YES	NO
1.	Attend (or attended) college	____	____
2.	Have own business	____	____
3.	Care if own children smoke	____	____
4.	Worry about future	____	____
5.	Sex after marriage only	____	____
6.	Did enter health profession	____	____
7.	Plan to live beyond 70	____	____

IV. Health Facts

		YES	NO
1.	Smoking less risk for women than men	____	____
2.	Air pollution as harmful as smoking	____	____
3.	Quit smoking when symptoms appear	____	____
4.	Smoking harmful to unborn babies	____	____
5.	Low tar eliminating risk of smoking	____	____
6.	Cancer and heart disease only risks	____	____
7.	X-rays effectively diagnose lung cancer	____	____
8.	Non-smokers physically harmed by smoker's air pollution	____	____

Copies of this tally sheet may be obtained from:

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

Example C: Student Smoking Survey - In order to develop an awareness of local student tobacco use, a short survey is desirable. Tabulation of the responses will help parents and teachers to identify the scope of usage and probable cause for usage. Local needs may be identified and proper programming initiated. The results may be examined by a parent group.

Directions: This is a survey and not a test. It is important that you answer each question truthfully. Please be honest and do not sign your name.

1. Your age: ______

2. Your Sex (check one): Female ______ Male ______

3. Does your mother smoke cigarettes now?

   ______YES ______NO ______Don't Know

4. Does your father smoke cigarettes now?

   ______YES ______NO ______Don't Know

5. How many brothers and sisters do you have?

   ______0 ______2 ______4

   ______1 ______3 ______More than 4

6. How many of your brothers and sisters smoke cigarettes? (Check one)

   ______0 ______2 ______4 ______Don't Know

   ______1 ______3 ______More than 4

7. Do you believe that smoking is immediately harmful to your health? (Check one)

   ______YES ______NO

8. Do you believe that it takes several years of smoking before it is harmful? (Check one)

   ______YES ______NO

9. Have you smoked any cigarettes during the last month? (Check one)

   ______YES, I have smoked at least one cigarette during the month.

   ______NO, I have not smoked any cigarettes during the last month.

***If your answer to number 9 is "yes" answer questions a, b, and c.

a. When you smoked, who was with you?

_____1) brother or sister

_____2) mother or father

_____3) I was alone

_____4) friend (s)

_____5) someone else

b. How did you get the cigarettes?

_____1) I bought them myself

_____2) They were offered to me without my asking for them

_____3) I got them from a pack belonging to someone else

c. If someone offers you a cigarette, but you really don't want to smoke it, is it easy or hard for you to say "no"?

_____ Easy to say no

_____ Hard to say no

_____ Don't know

***If your answer to number 9 is "no" answer questions y and z.

y. If you don't smoke, is it because: (you may check more than one)

_____1) you would get punished if you were caught?

_____2) you do not want to harm your body?

_____3) you do not like the smell of the smoke?

_____4) none of your friends smoke?

_____5) it costs too much money?

_____6) it interferes with playing sports?

_____7) smoking is a habit that is hard to break?

_____8) don't know

_____9) other (please explain)

z. If a friend of yours was thinking about starting to smoke, how could you discourage him or her from starting to smoke? Write your answer in the space below.

Example D: High School Smoking Survey - The results of the following survey will show a breakdown of reasons why the students smoke or do not smoke. The questions investigate a variety of topics ranging from the effects of advertising to the relationship of clubs and organizations and many areas in between.

An effective tabulation of the data can lead to an effective assessment of local needs related to tobacco abuse education. The results may help the parents and administrators to fully recognize the cause(s) and scope of the problem and plan related programming.

Directions: Place a check (✓) by the answers which apply to you, except where a number or letter is indicated. Please answer all questions truthfully. You need not sign your name. Thank you for your cooperation. We will let you know the results of this survey as soon as possible.

1. What is your school year or grade? __________

2. What is your age? __________

3. What is your sex? __________Male __________Female

4. School courses mostly __________Regents __________Non-Regents

5. Approximately what was the total average of all of your courses on your last report card?

__________ 50 or below

__________ 51-55

__________ 56-60

__________ 61-65

__________ 66-70

__________ 71-75

__________ 76-80

__________ 81-85

__________ 86-90

__________ 91-95

__________ 96-100

6. Have you ever taken or are you currently taking a health course?

_____ NO

_____ in junior high only

_____ in senior high only

_____ in both junior & senior high

7. Do your parents or guardians smoke?

_____ mother only _____father only _____both _____neither

8. Do you have any older brothers?

_____ YES _____ NO

9. If you answered "yes" to #8, do any of them smoke?

_____ YES _____ NO

10. Do you have any older sisters?

_____ YES _____ NO

11. If you answered "yes" to #10, do any of them smoke?

_____ YES _____ NO

12. Have you ever had any serious trouble in school?

_____ NO _____ occasionally have to stay after school

_____ have been suspended _____ frequently

13. Please list any clubs, organizations or other school groups to which you belong:

14. Please list any clubs, organizations or other groups outside of school to which you belong:

15. Cigarette advertisements are:

_____ Generally true and valid _____ Based on scientific research

_____ Questionable in truth _____ Checked by medical authorities before publication

16. Do you believe that cigarette filters in general are effective - trap and decrease the amount of irritating and dangerous substances without spoiling the taste?

_____ YES _____ NO

17. Do you believe that one of the main reasons coaches recommend that their athletes not smoke is because smoking handicaps atheletes by decreasing their strength of endurance and breath control.

_____ YES _____ NO

8

18. Do you believe that non-smokers live longer on the average than smokers?

_____ YES   _____ NO

19. Do you believe that cigarette smoking is related to the 4 leading causes of death in the United States - heart disease, cancer, vascular disease, and chronic respiratory diseases?

_____ YES   _____ NO

20. Do your friends smoke?

_____ none of them
_____ only a few of them
_____ about half of them
_____ most of them
_____ all of them
_____ Other (please specify)

21. Do you know any people who have cancer and do they smoke?

_____ don't know anyone with cancer.

_____ none of the people I know who have cancer ever smoked.

_____ all of the people I know who have cancer at one time or another were smokers.

_____ a few of the people I know who have cancer at one time or another were smokers

_____ most of the people I know who have cancer at one time or another were smokers.

***The next three questions (#22-24) are to be answered by non-smokers only!

22. If you have smoked and quit, what was your reason for stopping?

_____ have never even tried smoking

_____ only experimented - tried it once or twice

_____ health reasons

_____ too expensive

_____ boyfriend or girlfriend asked me to stop

_____ wanted to play sports

_____ felt it was a senseless habit and quit abruptly

_____ parents objected

_____ other (please specify):

23. Since you do not smoke, do you think that you ever will?

_____ do not ever intend to smoke

_____ have quit and never intend to smoke again

_____ definitely plan to begin smoking within the near future

_____ do not plan to now, but probably will after I graduate

_____ probably will after I get married

_____ do not plan to, but may smoke in the future for some reason

24. What are the most important factors in why you are a non-smoker? Place a check in the column that is most descriptive of your reaction to each factor.

	Great Influence	Some Influence	Little Influence	NO Influence
Religious Training				
Health Implications				
Expense				
Interest In Sports				
Parental Objections				

*** The remaining questions are to be answered by Smoker's only.

26. I continue to smoke because it:

_____ soothes my nerves

_____ is a habit

_____ gives me a lift

_____ is accepted by my social group

_____ gives me something to do with my hands

_____ curbs my appetite so I don't gain weight

27. How long have you been smoking regularly (nearly ever day, 3-4 times a week).

_____ a few weeks

_____ few months

_____ 6 months

_____ 1 year

_____ 1-2 years

_____ 2-3 years

_____ 3-5 years

_____ 5 years or more

_____ other (please specify)

28. Do you inhale when you smoke (take the smoke down into your lungs before breathing it out again)?

_____ YES

_____ NO

_____ only sometimes

29. Do your parents or guardians approve of your smoking?

_____ No

_____ they don't know about it

_____ they prefer that I do not smoke, but allow me to do what I want

_____ they approve

30. Is there any particular time of day that you enjoy or prefer a cigarette most?

_____ no - I like it anytime

_____ after meals

_____ during lunch period

_____ when I just get out of bed in the morning

_____ In the evening

_____ just before going to bed

_____ right after school

_____ on the way to school or when I get there

31. What type of cigarettes are you smoking?

_____ regular

_____ filter-tip

_____ king size regular

_____ menthol

_____ do not smoke cigarettes, but a pipe

_____ king size filter

_____ do not smoke cigarettes, but cigars

32. If you smoke cigarettes, approximately how many do you smoke each day?

_____ fewer than 5 cigarettes

_____ 5-9 cigarettes

_____ 10-15 cigarettes

_____ 20 cigarettes (1pack)

_____ 1-2 packs

_____ over 2 packs

_____ other (please specify)

33. How many years old were you when you began smoking.

_____ 10
_____ 11
_____ 12
_____ 13
_____ 14
_____ 15
_____ 16
_____ 17
_____ 18
_____ 19
_____ 20
_____ other (please specify)

34. Has the amount you smoke each day increased since you began smoking?

_____ YES
_____ NO

35. If you have no job, how do you obtain the cigarettes you smoke?

_____ have a job which gives me enough money to buy them
_____ with my allowance
_____ my parents supply them
_____ relatives or friends give them to me
_____ I "bum" them from others
_____ I sneak them
_____ other (please specify)

36. Would you like to stop smoking?

_____ YES
_____ NO

37. Since you are a smoker and know the advantages and the disadvantages of smoking, would you recommend smoking to others as a valuable habit to start?

_____ YES
_____ NO

Example F: Pre-Test - related to the Medical Hazards of Tobacco.

This list and the related statements, will assess the knowledge of a given group related to the medical hazards of tobacco and help to delineate future programming needs and curriculum directions.

Directions: Place a "T" in front of True statements;
Place a "F" in front of False statements.*

F 1. The cost of smoking one package of cigarettes a day for 40 years at 8% compound interest is approximately $40,000.
$70,000

T 2. All smokers suffer from some degree of chronic bronchitis.

F 3. Emphysema may usually be cured with medicines and surgery, or a combination of the two.
not curable

T 4. Lung cancer frequently produces no early symptoms

T 5. Light smokers using one to nine cigarettes daily shorten their life expectancy by approximately four years.

F 6. Before the age of 50, cigarette smokers and non-smokers have approximately the same risk of heart attacks.
3x the risk

F 7. Phlebitis is a condition marked by hardening of the inside of arteries.
inflammation of the lining of a vein -clot

F 8. Smokers show yellow staining of the teeth, but lose their teeth at approximately the same rate of non-smokers.
2x the rate

T 9. Smoking mothers have infants with birth weight approximately 7 ounces less than infants born to non-smoking mothers.

T 10. Smokers have a much higher incidence of cancer of the urinary bladder than non-smokers.

Copies of this test may be obtained from:

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

*Answers have been given for each statement for your convenience in making an answer key.

IV. Needs Assessment

Drug Education

Adults (Parents/Teachers)

Example A: The following questionnaire may be used in a combination parent-teenager workshop or in separate parent and teenager workshops related to drug abuse. This needs assessment tool may help bring a focus to the needed thrust of a given program. Ideally, both age groups should review the others' sheets (or use a tally sheet) so that common understandings or diverse opinions can be dealt with effectively.

	For Teenagers		For Parents
1.	Do you see any difference between marijuana and alcohol?	1.	Do you see any difference between marijuana and alcohol?
2.	Have you ever taken drugs to get high?	2.	Has your child ever been high on on drugs?
3.	Do you know anyone who takes drugs?	3.	Do your children associate with any drug users?
4.	Have you ever experimented with drugs to see what it is like?	4.	Have you ever experimented with drugs to see what it is like? Have your children done so?
5.	Do your younger brothers and sisters have access to drugs?	5.	Do you think your children under 13 have access to drugs?
6.	If you wanted drugs could you get them easily?	6.	If your children wanted drugs could they get them easily?
7.	Have your parents ever asked you directly, "Are you using drugs?	7.	Have you ever asked your child if he or she uses drugs?
8.	Is it possible to get high on something in your parent's medicine chest.	8.	Is there anything in your home that your children could get high on?
9.	Do your parents take too many pills?	9.	Do you believe you ever take too many pills?
10.	What are the reasons young people take drugs?	10.	What are the reasons young people take drugs?

Example B: The following needs assessment tool can be used to determine general drug knowledge for a given group. This can be a valuable asset in program planning. (Can be pre or post test).

		YES	NO	Don't Know
1.	Is marijuana physically addicting?	____	____	________
2.	Are barbiturates physically addicting?	____	____	________
3.	Is LSD physically addicting?	____	____	________
4.	Is aspirin a drug?	____	____	________
5.	Is heroin derived from marijuana?	____	____	________
6.	Is hashish a derivative of opium?	____	____	________
7.	Are amphetamines physically addicting?	____	____	________
8.	Are amphetamines found in sleeping tablets?	____	____	________
9.	Do barbiturates have a calming effect?	____	____	________
10.	Is methadone used for barbiturate withdrawal?	____	____	________
11.	Is heroin an opiate?	____	____	________
12.	Is mescaline derived from the marijuana plant?	____	____	________
13.	Is mescaline a psychedelic drug?	____	____	________
14.	Is cocaine physically addicting?	____	____	________
15.	Is continued glue sniffing injurious to the brain?	____	____	________
16.	Is alcohol a stimulant?	____	____	________
17.	Does heroin use always lead to addiction?	____	____	________
18.	Do you feel that you are knowledgeable about drugs?	____	____	________

19. What opiate is illegal in the U.S. even for medical purpose? ________

____

20. What class of drugs is commonly found in diet pills? ____________________

____

21. What is one kind of effect of amphetamines on the body? ________________

____

22. What are two main ways of administering heroin? ________________________

____

23. Name one psychedelic other than LSD? ____________________________

24. Hashish is most similar to what other drug? ______________________

____

25. Legally marijuana is classified as a ______________________________

by the Federal Government.

Example C : Drug Survey - A survey can help to determine opinions, interest and knowledge related to the drug problem. After compiling results, the scope of any localized drug problem may be assessed. The survey below may be applicable to many high school situations. Related to parents, the need for drug education and the influence of parental (and other social group) groups may be assessed.

Directions: Place a check by the answers which apply to you, except where a number or letter is indicated. Please answer all questions truthfully and please do not sign your name. Thank you for your cooperation. We will let you know the results of this survey as soon as possible.

1. What is your school year or grade? __________

2. What is your age? __________

3. What is your sex? __________ Male __________Female

4. School courses? __________ Regents __________Non-Regents

5. Have you ever taken drugs? ________ YES ________ NO

6. Do your parents or guardians take drugs?

______ mother only ______father only ______both ______other

7. Do your friends take drugs?

______ none of them ______about 1/2 of them ______ all of them

______ only a few of them _____most of them ______ other (please specify)

8. If you were offered a "reefer", a cigarette containing marijuana, would you smoke it?

_____ have already tried it

_____ smoke it regularly

_____ would try it to see what it was like

_____ would never try it

The next THREE questions (#9-11) are to be answered by non-drug users only.

9. If you have tried it and quit, what was your reason for stopping?

_____ have never tried drugs

_____ only experimented - tried it once or twice

_____ health reasons

_____ too expensive

_____ boyfriend or girlfriend asked me to stop

_____ wanted to play sports

_____ felt it was a senseless habit and quit abruptly

_____ parents objected

_____ other (please specify)

10. Since you do not take drugs, do you think that you ever will?

_____ do not ever intend to

_____ have quit and never intend to start again

_____ definitely plan to start within the near future

_____ do not plan to, but may in the future for some reason

11. What are the most important factors in why you are not a drug user? Place a check in the column that is most descriptive of your reaction to each factor.

	Great Influence	Some Influence	Little Influence	NO Influence
Religious Training				
Health Implications				
Expense				
Interest In Sports				
Parental Objections				

Questions #12-20 are to be answered only by people who take drugs?

12. What were the most important factors in your starting? Place a check in the column which is most descriptive of your reaction to each factor.

	Great Influence	Some Influence	Little Influence	NO Influence
Freedom from Parental Control				
Parents do it				
Being done by my social group				
Symbol of Adulthood				

13. I continue to take drugs because of:

_____ soothes my nerves

_____ it's a habit

_____ gives me a lift

_____ is accepted by my social group

_____ other (please specify)

14. Do your parents or guardian approve of this?

_____ no

_____ they don't know about it

_____ they prefer that I do not do it, but allow me to do what I want

_____ they approve

15. How old were you when you began? __________

16. Has the amount you take each day increased since you began?

_____ YES _____ NO

17. What is the approximate average weekly cost of maintaining your habit?

_____ $1.00 - 3.00

_____ $3.00 - 5.00

_____ $5.00 - 10.00

_____ $10.00 - 20.00

_____ Over $20.00
(Please specify) ____________________

18. If you have no job, how do you pay for your drugs?

_____ have a job which gives me enough money to buy them

_____ with my allowance

_____ my parents supply them

_____ relatives or friends give them to me

_____ I "bum" them from others

_____ Other (please specify)

19. Would you like to stop?

_____ YES _____ NO

20. Since you are a drug user and know the advantages and the disadvantages of this, would you recommend it to others as a valuable habit to start?

_____ YES

_____ NO

Everyone should answer the remaining questions.

21. On the left hand side please number in order of greatest physical harm, the five drugs which follow (1 - least dangerous; 5 - most dangerous)

_____ LSD (acid)

_____ Speed

_____ Barbiturates (sleeping pills)

_____ Heroin

_____ Marijuana

22. On the left hand side please check those drugs which you have used.

_____ LSD (acid)

_____ Speed

_____ Barbiturates (sleeping pills)

_____ Heroin

_____ Marijuana

_____ Cocaine

_____ None

23. Do you know someone who sells drugs?

_____ YES

_____ NO

24. Do you know someone whom you would consider a drug addict?

_____ YES

_____ NO

25. Do you think that the use of marijuana should be legalized?

_____ YES

_____ NO

26. Do you think that marijuana is more physically harmful than alcohol?

_____ YES

_____ NO

Example D: The following assessment of drug usage may be administered to both parents and students as a comparison and as a basis for educational need.

Have you ever taken any kind of illegal drugs before?

_____ YES _____ NO

* Answer questions 1-5 if you answered yes to the above statement.

1) What drug (s) have you taken? ____

____.

2) How old were you when you first took them? __________________________.

3) Do you take drugs regularly? (Once a week or more)

_____ YES _____ NO

4) Would you take any strange types of drugs?

_____ YES _____ NO

If so, what drugs might you take? ________________________________

____.

5) Why do you take drugs? What purpose do they serve you? ______________

____

* Answer questions 6-10 if you answered no to the above statements.

6) Would you ever take any kind of illegal drugs?

_____ YES _____ NO

7) Are they popular within your group of friends?

_____ YES _____ NO

8) Have you ever been offered any marijuana?

_____ YES _____ NO

9) Do you believe that these drugs serve the user a good purpose?

_____ YES _____ NO

10) What purpose do you think they serve? ____________________________

____

____.

Example E: Questionnaire Sheet - Drugs - Tricks or Treat

The following questionnaire will help to:

1) identify a smoking, drinking, and/or drug problems.
2) establish related attitudes
3) identify personal goals
4) ascertain opinions on basic health facts

After placing all the data on the tally sheet, the educator may identify the scope of drug use and related information for a given group. This may help to identify proper programming procedures needed for specific groups.

Directions: This questionnaire is to be completed in private and kept anonymous. Do not sign this sheet. Results from questionnaire sheets will be tabulated and you will be given a copy of the results. Answer each question as directly as possible by circling the best answer.

I. Prescription and Over-the-Counter Medications

1. Do you drink coffee or tea?

   (A) never (B) occasionally (C) regularly

2. Do you smoke or chew tobacco?

   (A) never (B) occasionally (C) regularly

3. Do you take antihistamines? (allergy medications)

   (A) never (B) occasionally (C) regularly

4. Do you drink alcoholic beverages?

   (A) never (B) occasionally (C) regularly

5. Do you take tranquilizers?

   (A) never (B) occasionally (C) regularly

6. Do you take sleeping pills?

   (A) never (B) occasionally (C) regularly

7. Do you use any pain medications other than aspirin/tylenol?

   (A) never (B) occasionally (C) regularly

8. Do you take any prescription medications prescribed for other persons?

   (A) never (B) occasionally (C) regularly

II. Marijuana

1. Do you use marijuana?

   (A) never (B) occasionally (C) regularly

2. Are you ever pressured socially to use marijuana?

   (A) never (B) occasionally (C) regularly

Answer questions # 3-8 ONLY if you use marijuana

3. If you use marijuana, do you use it?

   (A) To relax (B) To have fun

   (C) To get high (D) Becasue you feel forced to

4. If you use marijuana, how old were you when you first started?

   (A) 12 or below (B) 13-16 (C) Over 16

5. If you use marijuana, do you use it while drinking alcohol?

   (A) YES (B) NO

6. If you use marijuana, do you use it with other drugs?

   (A) YES (B) NO

7. If you use marijuana, do you use it?

   (A) alone (B) with friends (C) both

8. If you use marijuana, do you use it?

   (A) at home (C) at school

   (B) at parties (D) privately with friends

III. Uppers and Downers

1. Do you use any stimulants, such as amphetamines?

   (A) never (B) occasionally (C) regularly

2. Do you use any downers, such as barbiturates?

   (A) never (B) occasionally (C) regularly

3. If you use uppers or downers, do you use them at

(A) home (C) parties

(B) school (D) privately with friends

4. If you use uppers or downers, do you mix these with alcohol?

(A) never (B) occasionally (C) regularly

5. If you use uppers or downers, do you mix these with marijuana?

(A) never (B) occasionally (C) regularly

6. Have you ever been seriously depressed?

USERS: (A) YES (B) NO

NON-USERS: (A) YES (B) NO

7. Have you ever been arrested for any reason?

USERS: (A) YES (B) NO

NON-USERS: (A) YES (B) NO

8. Have you ever considered attempting suicide?

USERS: (A) YES (B) NO

NON-Users: (A) YES (B) NO

IV. Hallucinogens and Narcotics

1. Do you use LSD or other hallucinogenic drugs?

(A) never (B) occasionally (C) regularly

2. Do you use cocaine?

(A) never (B) occasionally (C) regularly

3. Do you use heroin?

(A) never (B) occasionally (C) regularly

4. Have any of your friends tried LSD or other hallucinogenic drugs?

USERS: (A) YES (B) NO

NON-USERS: (A) YES (B) NO

5. Have any of your friends ever tried cocaine?

USERS: (A) YES (B) NO

NON-USERS (A) YES (B) NO

6. Have any of your friends ever tried heroin?

USERS: (A) YES (B) NO

NON-USERS: (A) YES (B) NO

7. Have you ever known anyone who overdosed with narcotics?

USERS: (A) YES (B) NO

NON-USERS: (A) YES (B) NO

8. If you have ever tried LSD, cocaine, or heroin, who gave you your first dose?

(A) seller (B) friend (C) girlfriend or boyfriend

A copy of this questionnaire may be obtained from:

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

SAMPLE

TALLY SHEET FOR DRUG QUESTIONNAIRE

Directions: When questionnaire sheets have all been completed, tabulate the totals for each of the 8 questions on the 4 different sections by totaling the different answers on this Tally sheet.

I. Precription and Over-the-Counter Medications	Never	Occasionally	Regularly
1. Drink coffee or tea	____	____	____
2. Smoke or chew tobacco	____	____	____
3. Take antihistamines	____	____	____
4. Drink alcoholic beverages	____	____	____
5. Take tranquilizers	____	____	____
6. Take sleeping pills	____	____	____
7. Use any pain medication other than aspirin	____	____	____
8. Take other person's prescribed medication	____	____	____
II. Marijuana			
1. Use marijuana	____	____	____
2. Pressured to socially use marijuana	____	____	____

3. Why use marijuana

To Relax ____

To get high ____

To have fun ____

Forced ____

4. Age when first used

12 or below ____

13-16 ____

Over 16 ____

	YES	NO
5. Use while drinking alcohol	_____	_____
6. Use with other drugs	_____	_____

7. Use with whom — Alone ____________

With Friends ________________

Both ____________________

8. Use it where — At Home ________________

At School ________________

At Parties ________________

With Friends Privately ____________

III. Uppers and Downers

	Never	Occasionally	Regularly
1. Use stimulants such as amphetamines	_____	__________	_______
2. Use downers such as barbiturates	_____	__________	_______

3. Where use uppers and downers — Home ____________________

School ____________________

Parties ____________________

With Friends Privately ____________

4. Mix with alcohol	_____	__________	_______
5. Mix with marijuana	_____	__________	_______

		YES	NO
6. Serious depression	USERS:	_____	_____
	NON-USERS:	_____	_____
7. Been arrested	USERS:	_____	_____
	NON-USERS:	_____	_____
8. Considered or attempted suicide	USERS:	_____	_____
	NON-USERS:	_____	_____

IV. Hallucinogens and Narcotics	Never	Occasionally	Regularly
1. Use LSD or other halluconogenic drugs	____	____	____
2. Use cocaine	____	____	____
3. Use heroin	____	____	____

		YES	NO
4. Friends tried LSD or other hallucinogenics	USERS:	___	____
	NON-USERS:	___	____
5. Friends tried cocaine	USERS:	___	____
	NON-USERS:	___	____
6. Friends tried heroin	USERS:	___	____
	NON-USERS:	___	____
7. Know anyone who overdosed	USERS:	___	____
	NON-USERS:	___	____

8. Tried LSD, cocaine or heroin, who gave you your first dose.

Seller ________________

Friend ________________

Girlfriend or Boyfriend ____________

A copy of this Tally sheet may be obtained from:

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

Example F: Pre-Test (Post-Test) related to the Medical Hazards with Drug Abuse. This test, and the related statements, will assess the knowledge of a given group related to some of the medical hazards of drug abuse and help to delineate future programming needs and curriculum direction.

Directions: Place a "T" in front of True statements;
Place a "F" in front of False statements.

T 1. Every drug in the world is a potential poison with distinct medical hazards.

T 2. Antihistamines may be classified as downers.

T 3. Alcohol and tranquilizers should never be taken together.

T 4. Uppers may cause severe depression.

T 5. Heroin is not used in any form of legal medical practice.

T 6. An injection in the arm may cause an abscess in the brain.

T 7. Hepatitis may lead to cirrhosis.

F 8. Hallucinogenic drugs are chemicals which depress the brain and easily lead to overdose death.

T 9. Marijuana has been known to mankind for nearly 5,000 years.

T 10. Approximately 10% of all adults in the United States are alcoholics.

A copy of this test may be obtained from:

Spenco Medical Corp.
Box 8113
Waco, Texas 76710

Example G Drug Education

1. Which of these do you consider to be most harmful?

_____ Two drinks before dinner every night

_____ Smoking pot once a week

_____ Smoking a pack of cigarettes every day

2. Which of the following would you least like your children to do?

_____ Drinking two beers before dinner every night

_____ Smoking pot twice a week

_____ Smoking a pack of cigarettes a day

3. Which of these are you least likely to try?

_____ LSD

_____ Cigarette smoking

_____ Drinking cocktails

4. What do you think is the most effective way to discourage drug abuse?

_____ Horror stories from ex-addict

_____ Horror stories from policemen

_____ Factual information about the effects of drugs

5. If a friend were using LSD, which would you do?

_____ Report him/her

_____ Join him; go along with the crowd

_____ Avoid him/her

_____ Ask him/her to stop

6. If your son or daughter were smoking pot, which would you do?

_____ Report him/her to the authorities

_____ Ground him/her for two weeks

_____ Ignore it?

_____ Talk with him/her about it

7. If a parent were smoking heavily, how might you get him/her to stop?

_____ Send a letter saying how much you love him/her

_____ Leave the room whenever he/she smokes

_____ Hide his/her cigarettes

8. What might attract you to the use of drugs?

_____ The chance to expand your consciousness

_____ The need to go along with the crowd

_____ Curiosity

_____ The desire to escape boredom

_____ A wish for excitement, thrills

_____ The need to relax

9. If you came across someone pushing drugs to elementary school students, which would you do?

_____ Report him/her

_____ Ignore it

_____ Tell the students to stay away

10. Which of these facts would discourage you from using alcohol?

_____ An alcoholic's life span is shortened by ten to 12 years

_____ In half the murders in the United States, either the killer or the victim, or both, have been drinking

_____ Alcohol costs $15 billion per year in the United States just in terms of time lost from work

11. In your home, what is your attitude toward drugs?

_____ Total abstinence

_____ Laissez-faire

_____ Parents encourage the children to try alcohol (and praise their ability to hold their liquor)

12. How do you perceive alcohol?

_____ As a socializer

_____ As a tranquilizer

_____ As a depressant

13. Which do you prefer?

_____ Beer

_____ Wine

_____ Hard liquor

_____ Milk

14. What would you rely on if you needed help in breaking a habit?

_____ Self-discipline

_____ Talking with a friend

_____ Talking with your doctor

15. If you were a senator voting on how to allocate $1 million, what would be your priorities?

_____ Drug-abuse educational programs

_____ Drug-counseling crisis centers

_____ Long-term drug-rehabilitation centers

16. Through which of these would you prefer to expand your consciousness?

_____ Meditation

_____ Pot

_____ Reading

17. What is the best way to "control"drug abuse?

_____ Decriminalization

_____ Harsh penalties

_____ Educational programs

18. Regarding drugs, to whom would you be most likely to listen?

_____ An ex-addict

_____ A physician

_____ Policeman

_____ Peers

19. Which of these is your position?

_____ There is no drug abuse problem

_____ Legal drugs are abused

_____ Illegal drugs are abused

20. Regarding drugs, which of the following would be your motto?

_____ "Curiosity killed the cat"

_____ "Try it, you'll like it"

_____ "I'd rather fight than switch"

_____ "You only go around once in life-get all the gusto you can"

21. Which of these do you consider to be most harmful?

_____ A parent with a violent temper

_____ A parent who is an alcoholic

_____ A family in which there is no love between the parents

22. What do you think our country's priorities should be?

_____ Drug education

_____ Ecology

_____ Poverty

23. Who do you think should be responsible for drug education?

_____ The family doctor

_____ The home

_____ The school

VOTING QUESTIONS

How many of you:

1. Think there should be a minimum age for drinking?
2. Think that the minimum drinking age should be fifteen? Eighteen? Twenty-one?
3. Think there should be a minimum age for smoking?
4. Think that marijuana should be decriminalized?
5. Have ever faked your age in order to get a drink?
6. Know someone who is hooked on alcohol? On cigarettes?
7. Have tried to talk with that person?
8. Think smoking should be banned in public places?
9. Have ever driven after drinking?
10. Have "quit smoking" at least once?
11. Would like to stop smoking?
12. Think you'll smoke or drink when you're older?
13. Hope your children won't smoke or drink?
14. Have ever considered putting up a no-smoking sign in your house?
15. Offer guests a drink in your home?
16. Have ever gone bar-hopping?
17. Take aspirin when you have a headache?
18. Drink at least two cups of coffee each morning?
19. Have ever had a hangover?
20. Think restaurants should have smoking and nonsmoking sections?
21. Drink or smoke more now than you did three years ago?
22. Get drunk at least once a month?
23. Consider alcohol to be a drug?
24. Would consider using a sleeping pill?
25. Take novocaine when you go to the dentist?
26. Enjoy taking such medicines as cough syrup?
27. Think doctors are too drug-oriented?
28. Think that the society was right in passing Prohibition laws?
29. Think teachers should have the right to search students' lockers?
30. Smoke cigarettes and enjoy it?

LEGALITY AND POLICY

LEGALITY & POLICY

Section Contents

Legal Aspects pertaining to chemical substances

- Alcohol
  - Historical perspective
  - Previous laws
  - Present laws
  - Federal controls
  - State controls
  - County controls
  - Influence on deviant behavior
  - Legal procedures for DWI and DWAI
- Drugs
  - Drug offenses and penalties in New York State
  - Separate laws for Marijuana in New York State
  - Legal status of paraphenalia shops

Developing policies and procedures for Drugs and alcohol

- Major considerations in writing policy
- Other considerations in writing policy
- Specific questions administrators, faculty, and students should ask - so the policy encompasses all answers.
- Importance of reinforcing the policy and curriculum with training or inservice programs.

Suggested guidelines for schools in handling drug related incidents

Policy for Search and Seizure

- Court cases involving violation of search and seizure.
- Other legal considerations regarding accusations, etc.
- Importance of confidentiality in drug related matters.

Policy and procedures for dealing with employees regarding smoking, alcohol and drug problems.

- Criteria to judge whether an employee or student has a drug problem.
- Sample Board of Education Policy on Drug Abuse Prevention.

Comprehensive school smoking policy

- Educational goals
- Containment of smoking area
- Enforcement and discipline
- Blueprint for a High School Smoking Cessation Clinic
- Sample of New York State school policies permitting and forbidding smoking

Some Suggestions on writing your Congressman

LEGALITY & POLICY

An Outline of Legal Aspects pertaining to Chemical Substances

I. Alcohol

A. Prohibition 1920-1933, the 18th amendment to the constitution made it illegal to drink any alcohol anywhere in the U.S.

1. Made all drinkers criminals.
2. Manufacture, transportation and sale of alcohol were illegal.
3. Supplying illicit liquor to people who drank was the start of organized crime in the U.S.

B. Prohibition amendment was repealed in 1933 for many reasons.

1. Franklin D. Roosevelt used this as one of his platforms if he was elected president.
2. U.S. was in a depression and the alcohol industry would promote many jobs.
3. The government could regulate the manufacture of alcohol so the beverage would be pure and non-toxic (In 1927, 12,000 people died from ingestion of methyl (wood) alcohol).
4. The government could collect a tariff from the beverage.
5. The crime element would be eliminated.
6. The court system was already overcrowded and juries would rerely convict violators.
7. By 1930, the "wets" were outdoing the "drys".
8. Federal, state, and local governments controlled various laws governing alcohol.

    a) Federal controls

    1. Regulate manufacturing and concentration of alcoholic beverages.
    2. Allow collection of tariffs.
    3. Forbid private making of any distilled alcohol.
    4. Regulate quantities of homemade beer and forbid the sale of the same.

    b) State controls

    1. Set the legal drinking age for the state.
    2. Set the BAC - Blook Alcohol Concentration level for determining DWI or DWAI.
    3. Make the laws pertaining to DWI or DWAI.
    4. Govern the laws pertaining to public intoxication.
    5. Regulate issuance of licenses to stores and bars to sell beverages and set penalties for violation of laws.

c) County controls

1. Regulate the number of bars within a confined area and relationship to influence on minors.
2. Set times of day beverages can be sold.
3. Establish days beverages can be sold.

C. Recognition of Alcohol's influence on deviant behavior becomes subject of many laws.

1. Categories of crime

   a) Traffic violations - no criminal record if charged.
   b) Misdemeanor - a less serious offense, lighter fines and penalties.
   c) Felony - serious crime - greater fines and penalties.
   d) Liquor control violations for stores and bars.
   e) Falsifying identification

2. Public intoxication alone is no longer a crime in New York State (See document 1).
3. Many crimes of violence are caused by alcohol abuse.
4. Incidence of crime is higher among drinkers.
5. Cost of crime is influenced by alcohol abuse.
6. Drinking and driving has long been recognized as hazardous.

D. Legal procedures for DWI and DWAI.

1. Suspect stopped by police must present driver's license, car registration and insurance card.
2. If suspect has been driving, a "breathalyzer" test is performed for Bloo Alcohol Concentration.

   a) Under .05 - not considered DWI or DWAI, person can continue driving.
   b) Between .06-.09 you might be charged with driving while ability is impaired (DWAI), person can not continue driving and will be taken to the station and booked.

      1. Usually released to the custody of family or friend.
      2. A conviction at a later hearing date could mean

         - 15 days in jail
         - fine up to $50.00 or both
         - loss of license for 60-90 days
         - carries the possibility of using a restricted license for work or business

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5. Cost of crime is influenced by alcohol abuse.
6. Drinking and driving has long been recognized as hazardous.

D. Legal procedures for DWI and DWAI.

1. Suspect stopped by police must present driver's license, car registration and insurance card.
2. If suspect has been driving, a "breathalyzer" test is performed for Blood Alcohol Concentration.

    a) Under .05 - not considered DWI or DWAI, person can continue driving.
    b) Between .06-.09 you might be charged with driving while ability is impaired (DWAI), person can not continue driving and will be taken to the station and booked.

    1. Usually released to the custody of family or friend.
    2. A conviction at a later hearing date could mean

        - 15 days in jail
        - fine up to $50.00 or both
        - loss of license for 60-90 days
        - carries the possibility of using a restricted license for work or business

c) .10 or more BAC will be considered DWI or Driving While Intoxicated

- first offense - misdemeanor
- you will be photographed and fingerprinted copies are filed with the state, local police, and FBI
- conviction could mean up to one year in jail and a maximum $500 fine or both
- driver's course may be recommended by the judge to the Department of Motor Vehicles for DWI OR DWAI
- license will be revoked for at least 6 months (See document 2)
- second offense in 10 years is a felony

E. Driving under the influence of drugs draws the same penalties as DWI.

F. The cost of that last drink - add it all up.

- The Motor Vehicle Department fees
- The cost and inconvenience of the drinking driver's course
- The cost of the standard driving and written tests
- Loss of license
- Prospect of a jail term and a fine
- DWAI or DWI record to follow you the rest of your life
- DWAI or DWI conviction will be a mark on your license
- Increase in your automobile insurance
- Not to mention your notoriety in Police Beat

II. Drugs

A. Using controlled drugs for other than medical reasons is against the law (See document 3) for current drug laws for sale or possession.

B. Since marijuana has been discriminalized in New York State separate laws have been passed pertaining to its abuse. (See document 4).

III. Drug paraphernalia

A. A dozen states and scores of municipalities have passed laws or are in the process of passing laws banning drug paraphernalia for two basic reasons:

1. The availability of paraphernalia gives the message to young people that drug use will be tolerated.

2. It glamourizes drug use and preys on drug fantasies.

B. Paraphernalia users are fighting legislation on two grounds

1. Magazines, books, advertisements and other printed material involving drugs are protected by the first amendment upholding free speech.

2. Laws aimed at banning paraphernalia items have run afoul of the courts becasue they have been too broad.[1]

(See document 5)

(See document 6)

DEVELOPING SCHOOL POLICIES AND PROCEDURES FOR DRUGS AND ALCOHOL

An Outline

I. Major considerations in writing policy.

- A. The policy should establish clear lines of authority and responsibility.
- B. It should provide consideration for due process of the students and staff.
- C. The policy should be legally sound so it allows staff to carry on their legal responsibilities without anxiety.
- D. All policy drafts should be checked out by the school's attorney before making them official.

II. Other considerations in making drug policy and procedure.

- A. Drug use is common in students inside and outside of school. (Verify by needs assessment).
- B. There are positive steps that can be taken to reduce chemical substances.
- C. Students must be dealt with differently than adults as they often do not fully realize the consequences of their action.
- D. Discipline should concern the total mental and moral development of each student.
- E. Expulsion may have the potential of intensifying the drug use of the student involved. (See other alternatives in section of this manual on Alternatives).
- F. In making policy, it should keep within the framework of the New York State Regent's Action Plan, (Education Laws and Commissioner's Regulations) (See document 7).
- G. Policy review should include a cross section of the school/community: administration, teachers, students, school nurse, counselors, parents, drug and alcohol professionals, and law enforcement officials.
- H. Every school is unique and the policy should fit the school.

III. Questions to address during a policy review as an administrator.

- A. Do you have a process that is effective in responding to drug and alcohol situations?
- B. Does this process protect both staff and students from legal involvement or embarassment?
- C. Are there well known procedures for the staff to use when they encounter a drug situation?
- D. Have you made it clear what is expected from staff, students, and their parents?
- E. Are you sure this process is legal?
- F. Do you treat all students on an equal basis in this process, without regard for grades, athletic ability, or other factors?

IV. Questions to address during a policy review as a faculty member.

- A. Do you understand what to do when you come across someone you suspect as using a drug?
- B. What do you do when you encounter information about a student using drugs?
- C. Do you know the legal aspects of drug and alcohol use?
- D. Would you be acting illegally if you don't contact the authorities with such information? What can happen if you do?
- E. Do you know what to say to a student who wants advise or to talk about problems?
- F. Do you understand the liabilities and responsibilities you encounter when working with students?
- G. Do you have a policy or procedures from the school which make it clear about what you're supposed to do in a drug/alcohol situation?

These are good overall questions to be considered in making school policy. Your answers to some of these questions may indicate areas in need of revision or development within your policy for alcohol and drug use.

V. Questions to address during a policy review as a student.

- A. Do you know what to expect if you get involved in a drug/alcohol related situation?
- B. Do you understand the disciplinary process?
- C. Do you know how to get information or counseling about alcohol or drug use?
- D. Do you know what to do if a friend is abusing drugs/alcohol?
- E. Do you know the legal aspects of drug and alcohol use?

VI. Reinforcing the policy and curriculum with training.

- A. The effectiveness of the policy depends on adequate training of all your staff and getting the "message" to students and their parents.
- B. Training should be carried out by knowledgeable personnel.
- C. Specific training is needed for school counselors in counseling and referring drug-using or dependent individuals.
- D. Training is necessary regarding specific problems of school nurses in handling emergency drug situations.[2]
- E. General instructions should be given to all staff members in prevention activity, alternative activity and affective education.

VII. Sample suggested guidelines for handling drug related incidents. (See document 8)[3]

VIII. Policy for Search and Seizure

A. Searches/key things to remember (See document 9)[4]
B. Considerations for conducting searches (See document 10)[5]
C. Other considerations on Search and Seizure (See document 11)[6]
D. Court cases pertaining to Search and Seizure (See document 12)[7]

IX. Legal considerations (See document 13)[8]

A. Reporting to parents or legal guardians any drug related incidence
B. Due process
C. School records

X. Confidentiality (See document 14)[9]

A. Pertaining to confidence of professionals or paraprofessionals
B. School records

XI. Making policy and procedures for employees with drug problems

A. Many hours on the job are lost, and job efficiency affected by employees with a drug or alcohol problem
B. Policy should be clear verbally and restated to employees in a handbook or policy brochure
C. Sample policy statements

1) (See document 15)[10]
2) (See document 16)[11]

D. Criteria to judge whether an employee or student has a drug problem

1) (See document 17)[12]
2) (See document 18)[13]
3) (See document 19)[14]

XII. Sample Board of Education Policy on Drug Abuse Prevention

(See document 20)[15] and (document 21)[16]

XIII. Comprehensive school smoking policy

A. Should define educational goals (see Commissioner's Regulations from the Board of Regents - State of New York - document 7)
B. Containment and confinement of smoking area important for the safety of everyone as far as fire code and "Right to Clean Air" (See State of New York Legislation on Smoking and Clean Air Act dated February 6, 1979 - document 22)[17]
C. Enforcement and discipline are essential to the policy
D. Sample of Model Smoking Policy (See document 23)[18]

  E. Blueprint for a High School Smoking Cessation Clinic (See document 24)[19]
  F. Samples of New York State school policies permitting and forbidding smoking (See document 25)[20]

XIV. Some suggestions on writing your Congressman (See document 26)[21]

XV. Operational definitions (See document 27)[22]

FOOTNOTES

1. "Head Shops: Gateway to the Drug Scene", Michael Satchell, Parade, Syracuse Herald American, June 15, 1980.

2. "Responding to Student Drug Use: Guidelines for School Personnel," Governor's Council on Drug and Alcohol Abuse, Pennsylvania Dept. of Education, April 1980-pp 3-5.

3. Ibid. pp.9-10

4. Ibid. p. 8

5. Ibid. pp. 16-17

6. "Guidelines for Development of School Drug Policies", Onondaga - Madison BOCES, Alcohol-Drug Abuse Prevention and Education Program, March 81, pp. 29-31.

7. Delivered at Wyoming Seminary, "Schools, Youth, and Substance Abuse: An Institute on the Problems and Solutions for Education", by Deborah Beck, on July 1, 1981.

8. Onondaga-Madison BOCES, op. cit., p 20.

9. Ibid. p. 21

10. "Developing an Occupational Drug Abuse Program", U.S. Dept. of Health Education and Welfare, Public Health Services, Alcohol, Drug, Abuse, and Mental Health Administration, 1978, pp. 49-53

11. Onondaga Madison BOCES, op. cit., pp. 22-23.

12. Delivered at Wyoming Seminary, "Schools, Youth, and Substance Abuse: An Institute on the Problems and Solutions for Educators", by Deborah Beck, July 1, 1981.

13. Source unknown

14. "Pre-Program Information Assessment for Alcohol Awareness, Early Intervention: A Model for High Schools, Early Intervention and Confrontation", Cortland County Alcoholism Services.

15. Onondaga - Madison BOCES, op. cit., pp. 12-18.

16. "Model Drug Policy" - Putnam/Westchester BOCES, September 1974.

17. "Guidelines on Smoking", State Education Department, pp. 26-28.

18. "Comprehensvie School Smoking Policy", Jeanette Dippo.

19. "Guidelines for Development of School Policies Regarding Smoking", State Education Department, 1980, pp. 29-31.

20. Ibid. p. 20.

21. Right to Write, Office of Government Relations and Citizenship, NEA, September 1971.

22. Onondaga - Madison BOCES, op. cit., p. 19.

SOME LEGAL ASPECTS

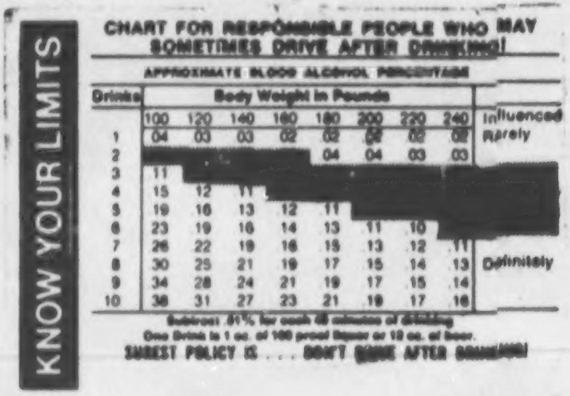
DWI--(driving while intoxicated)
A person is considered legally too drunk to drive when the percentage of alcohol in the bloodstream is .10% or more.

FACT: It is unlawful for both the driver and the passengers to drink while an automobile is in motion or parked.

FACT: It is unlawful to possess an open bottle of liquor while in an automobile.

FACT: While there is no law concerning public intoxication, there is a law concerning disorderly conduct and disturbing the peace.

Clip out and keep the chart below in your wallet. Know YOUR legal limits!



KNOW YOUR LIMITS

CHART FOR RESPONSIBLE PEOPLE WHO MAY SOMETIMES DRIVE AFTER DRINKING!

APPROXIMATE BLOOD ALCOHOL PERCENTAGE

Drinks	Body Weight in Pounds								
	100	120	140	160	180	200	220	240	Influenced
1	04	03	03	02	02	02	02	02	Rarely
2	[illegible]	[illegible]	[illegible]	[illegible]	04	04	03	03	
3	11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
4	15	12	11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
5	19	16	13	12	11	[illegible]	[illegible]	[illegible]	
6	23	19	16	14	13	11	10	[illegible]	
7	26	22	19	16	15	13	12	11	
8	30	25	21	19	17	15	14	13	Definitely
9	34	28	24	21	19	17	15	14	
10	38	31	27	23	21	19	17	16	

Subtract .01% for each 40 minutes of drinking
One Drink is 1 oz. of 100 proof liquor or 12 oz. of beer.
SAFEST POLICY IS . . . DON'T DRIVE AFTER DRINKING!

CHARGE	BAC	CATEGORY	COURT	MOTOR VEHICLE
DWAI #1192.1	.08-.09	Violation	$250 Fine 15-Days in Jail	60 Days-Suspension
Second	Could result in Jail sentence			Multiplied effect i.e., 2nd-DWAI-120 Day Suspension; 3rd-DWAI-240 Day Suspension
DWI #1192.2	.10 or above	Misdemeanor	$1,000 Fine 1-Year Jail 3 Years Probation	6 months revocation of license
SECOND DWI within 10 years		Felony	3-1/2 Years Jail 5 Years Probation	Reapply for license After Court Satisfied
Reckless Driving (Plea) #1190		Misdemeanor	Fine	3 points (If accident involved Motor Vehicle could call you in for hearing)

SCHEDULE OF DRUG OFFENSES AND PENALTIES UNDER NEW YORK STATE PENAL LAW (ARTICLE 220)

Unlawful Sale

	A-I FELONY	A-II FELONY	A-III FELONY	B FELONY	C FELONY	D FELONY	A MISDEMEANOR
Narcotic Drug	1 oz or more of a substance containing a narcotic drug.	1/8 oz to 1 oz of a substance containing a narcotic drug.	Any amount.				
Hallucinogens		125 mg or more	25 mg or more, any amt. with previous drug offense conviction		Any amount with previous D felony sale conviction	Any amount.	
Hallucinogenic Substances		5 g or more.	1 g or more; any amt. with previous drug offense conviction		Any amount with previous D felony sale conviction	Any amount.	
LSD		5 mg or more.	1 mg, any amt. with previous drug offense conviction.		Any amount with previous D felony sale conviction	Any amount.	
Methamphetamine		1/2 oz or more of a substance containing methamphetamine.	1/8 oz or more of a substance containing methamphetamine; any amt. with previous drug offense conviction.		Any amount with previous D felony sale conviction	Any amount.	
Stimulants		5 g or more.	1 g or more; any amt. with previous drug offense conviction.		Any amount with previous D felony sale conviction	Any amount.	
Dangerous Depressants				Second offender of C felony sale of dangerous depressant or narcotic preparation.	10 oz or more. Any amt with previous D felony sale conviction.	Any amount.	
Depressants					2 lbs or more. Any amt. with previous D felony sale conviction.	Any amount.	
Narcotic Preparations				Any amount to a person under 21; second offender of C felony sale of dangerous depressant or narcotic preparation.	Any amount.		
Marijuana					Any amount.		
Any Controlled Substance					Any amount with previous D felony sale conviction.	Any amount.	

	A-I FELONY	A-II FELONY	A-III FELONY	B FELONY	C FELONY	D FELONY	A MISDEMEANOR
PENALTIES:	15 yrs.-life mandatory life sentence; if paroled, life parole.	6 yrs.-life, mandatory life sentence; if paroled, life parole.	1 yr.-life, mandatory life sentence, if paroled, life parole.	1-25 yrs. mandatory imprisonment.	1-15 yrs. mandatory imprisonment except for marijuana.	1-7 yrs.	To 1 yr.
OTHER COMMENTS:	Plea bargaining within A-felony class only.	Plea bargaining within A-felony class only.	Plea bargaining within A-felony class only. Life probation available under certain circumstances.	Conspiracy to commit an A-felony, is a B-felony, bribery and bribe receiving in a drug case is a B-felony.	Probation available for first marijuana violation; rewarding and receiving a reward for official misconduct in a drug case can be a C-felony or E-felony.	Probation available.	Probation available.

OTHER CRIMINAL ACTS

Act	Penalty	Description
Criminal Injection of a Narcotic Drug (Class E Felony).	1-4 years	Intentionally injecting a narcotic drug into another's body with the latter's consent.
Criminal Possession of a Hypodermic Instrument (Class A Misd.).	To 1 year	Possession of a hypodermic needle or syringe.
Criminal Use of Drug Paraphernalia: First Offender (Class A Misd.).	To 1 year	Possession and sale of dilutents, adulterants or packaging materials for the unlawful mixing or distribution of narcotic drugs or stimulants.
Criminal Use of Drug Paraphernalia: Second Offender (Class D Felony).	1-7 years	Second conviction of paraphernalia crime.
Criminal Possession of a Precursor of a Controlled Substance (Class E Felony).	1-4 years	Possession of carbamide (urea), ergot, pentazocine, etc., with certain other chemicals.
Loitering 1st (Class B Misd.).	To 3 mos.	Being in any place for the purpose of unlawfully using or possessing a controlled substance.

SOME STREET SALE DOSAGE LEVELS

Heroin: There are usually 10 milligrams of pure heroin per bag.
LSD: There are 125 micrograms of the drug in each dose.
Marijuana: There is up to one gram of the drug per cigarette.
THC: There are 7.5 to 22.5 milligrams of the drug per marijuana cigarette.
Stimulants: There are 5 to 15 milligrams per commercial dose. An abuser uses 100 to 400 milligrams per day.
Methamphetamine: There are 2.5 to 7 milligrams per dose.
Dangerous Depressants: There are 50 milligrams of Seconal in a standard tablet. There are 30 milligrams of Phenobarbital in a standard tablet. An abuser uses 4 to 10 tablets per day.

DEFINITIONS

1. "Marijuana" includes Hashish.
2. "Narcotic Drugs" includes opiates, opium, cocaine, heroin, codeine and methadone.
3. "Narcotic Preparations" includes nalorphine or other opiate preparations.
4. "Hallucinogens" includes psilocybin, dimethoxyamphetamine, peperidyl benzilates, psilocyn, tetrahydrocannibionols other than marijuana.
5. "Hallucinogenic Substances" includes some amphetamines, ibogaine, bufotenine, DET, DMT, mescaline, peyote.
6. "Stimulants" includes most amphetamines, methamphetamine, phenmetrazine, methylphenidate.
7. "Dangerous Depressants" includes methaqualone, barbituric acid derivatives, barbitol, phenobarbitol.
8. "Depressants" includes chloral betaine, chloral hydrate, meprobamate.
9. "Controlled Substances" includes all of the above and any other drugs listed in Schedules 1-V of Section 220.22 of the Penal Law.
10. "Sale" includes the giving of the offering to give to another. Marijuana only - Probation available for first offense.

NEW LAW - Highlights

* Life Parole - If parole conditions are violated, can be returned to serve out life sentence.
* All drug convictions (except first offenders - marijuana) must serve time in State Prison - no probation - no County Jail.
* No change in marijuana laws - sale of any amount is still subject to 15 years prison.
* No change in definition of "sell". Can still mean "give".
* Methaqualone - (sopors) now covered. Sale of any amount, 1-7 years.
* If previously convicted of felony then must serve time in State Prison - upon new conviction - no probation - no County Jail.
* Conspiracy to commit any A felony is a B felony.
* Bribery and bribe receiving in a drug case is a B felony.
* No probation in B and C drug felonies.
* Imprisonment is mandatory in Class C felonies except marijuana.
* Upon conviction for an A felony, no bail pending appeal; no certificate of reasonable doubt.
* Informants eligible for Life Parole if approved by Administrative Judge.
* $1,000.00 reward for information in a drug felony.

D-6

THC, MARIJUANA, CANCER PATIENTS, AND NORML
IS THE TAIL WAGGING THE DOG?

In February, 1979, Keith Stroup, then-outgoing director of the National Organization for the Reform of Marijuana Laws (NORML), told Emory University students that NORML was trying to get marijuana reclassified medically. "If we do that, and we'll do it in at least 20 states this year for chemotherapy patients," he said, "*we'll be using the issue as a red herring to give marijuana a good name.* That's our way at getting to them indirectly, just like the paraphernalia laws are their way at getting to us."

The extent to which NORML has been willing to exploit terminally ill cancer patients for its own political ends is appalling. We will never fully understand how successfully NORML has hoodwinked us, however, unless we are willing to plow through some technical information researchers have learned about marijuana and THC in the clinic. To do this, we must first understand the scientific method — the process by which a theory becomes accepted medical fact.

When a scientist gets an idea, he designs an experiment to test whether or not his idea will work. He writes down the steps he takes to test his idea and publishes both the design of his experiment and the results he achieved. His findings do not become accepted scientific fact, however, until other scientists have duplicated his experiment and achieved the same results.

The most reliable experiment a scientist can design is a double-blind, cross-over study. Because most of us don't know what a double-blind, cross-over study is, NORML has been able to convince the public and the press that marijuana relieves chemotherapy patients' nausea, *in spite of the fact that not one double-blind, cross-over study giving marijuana to cancer patients has been done to verify this.*

HOW DOES A DOUBLE-BLIND, CROSS-OVER STUDY WORK?

Suppose a scientist theorizes that Vitamin C will relieve headaches. He designs an experiment to test his theory. He produces two kinds of red pills. One contains Vitamin C, the other — which looks exactly the same — contains sugar. This second pill is called a placebo.

Laboratory technicians help the scientist with his experiment by numerically coding the pills. The scientist selects twenty patients who suffer from headaches and divides them into two groups. He decides to give each patient one pill a day for two weeks. The first week, Group One gets the Vitamin C pill and Group Two gets the placebo. The study is called "double-blind" because the patients do not know which pill they are getting. *Neither does the scientist.*

The study is called "cross-over" because at the end of the first week, the pills are reversed. This time, Group One gets the placebo and Group Two

Source: Families In Action
No. 2/3, June/September 1980

gets Vitamin C. Still, neither scientist nor patient knows who's getting what. But during the two week period, patients are reporting whether or not their headaches are going away and the scientist is recording this information.

Now, suppose all the patients in Group One got rid of their headaches after taking the red pill the first week, but their headaches continued after taking the pill the second week. At the end of the experiment, the scientist breaks the code. Only then does he find out that Group One received Vitamin C the first week and the placebo the second week. Now he can correlate his data and see that he's proved his theory — that Vitamin C does in fact relieve headaches. From this hypothetical example we can see that double-blind, cross-over studies guarantee no preconceived notion or bias, on the part of the scientist or the patient, can influence the patient's reaction to the drug being tested.

THC IN MARIJUANA IS LIKE PENICILLIN IN BREAD MOLD

Now that we understand what a double-blind, cross-over study is, let's set up another hypothetical situation. Suppose lots of people were suffering from strep throat. Suppose some of these people accidentally discovered that when they ate moldy bread, their strep infections disappeared. The scientist would want to find out what drug in the mold was relieving the patients' symptoms. Let's say he analyzes the bread mold and discovers a drug in the mold which he names penicillin. He speculates that penicillin is what's giving the patients relief. Now he has to prove it.

He figures out how to separate the penicillin from the bread mold. This is called extracted penicillin. He places extracted penicillin into capsules and a placebo into identical capsules and conducts a double-blind, cross-over study to test his theory. He finds that the patients in his study who received penicillin capsules recovered from their strep infections while the patients who received the placebo did not. The scientist proved his theory, but now he has a new problem.

He has to find a way to grow enough mold to produce penicillin in large enough quantities to extract it and distribute it to all patients who suffer from strep throat. A more efficient way to make the drug available to everyone who needs it would be to determine what the chemical structure of extracted penicillin is and then duplicate it in the test tube, using pure chemicals. This is called synthesized, or synthetic, penicillin. The molecular structure of synthetic penicillin is exactly the same — a chemical mirror image of the molecular structure of extracted penicillin. By synthesizing penicillin, the scientist is able to eliminate the mold growing process, which is time consuming and very expensive.

While this next part is *not* true about penicillin, it is true about marijuana, so we're going to push our penicillin analogy a little further to understand what researchers have been finding out about THC and pot. Let's suppose that during their initial research, scientists discovered that natural penicillin, whether it's still in bread mold or has been extracted from it, has some problems. When exposed to light it loses potency and the longer it sits on the shelf the more potency it loses. Now, a doctor has to know that when he prescribes 250 milligrams of penicillin every four hours that's what you're going to get — not 250 milligrams the first few times and then, as the drug loses its potency, 200 or 100 or even 50 milligrams a few doses later. Because synthetic penicillin is produced and stored under controlled conditions, its potency is much more stable, which makes it a far more acceptable drug for medication.

NORMBL?

We've got one more analogy to go and this one's political rather than scientific. We all know it can't, but for the purpose of this discussion, let's assume that eating bread mold makes people high. And let's assume there are laws against eating, selling, and smuggling bread mold. Let's finally assume that a movement to legalize bread mold develops and somebody puts together a National Organization for the Reform of Moldy Bread Laws (NORMBL). Initially, NORMBL figures the way to legalize bread mold is to lobby state legislatures to "decriminalize" moldy bread. After all, it doesn't seem very fair to throw one moldy bread eater in Arizona in jail for five years when a guy eating bread mold in Ohio gets off scott free. So everything's going along pretty well for NORMBL. Eleven states decriminalize bread mold and most of the others don't pay much attention to your average moldy bread eater who's fungusing out in the privacy of his own living room.

As bread mold becomes more socially acceptable, folks start designing moldy bread paraphernalia and "bread shops" pop up in suburban shopping malls like mushrooms after a spring rain. Mold culture magazines hit the newsstands and "grow your own bread mold" books flood the book stores. Most of the bread paraphernalia is designed to appeal to kids, and, pretty soon, kids get the idea that moldy bread highs are for them, too. All over the country kids start eating bread mold — even little kids. And with that, parents revolt. They start passing laws to close down "bread shops" and form groups to educate about the harmful effects of bread mold. *No more states pass decrim laws.* NORMBL is furious, but can't do much to stem the tide.

Meanwhile, evidence is mounting — from double-blind, cross-over experimental research studies — that synthetic penicillin is the drug that is going to give the largest number of strep throat patients the most relief. True, strep throat patients who eat bread mold will get some relief because of the penicillin that's in the mold, and while all of the research is going on more and more of them eat bread mold because that's all that's available to them. But, as we have already seen, natural penicillin is unstable and loses its potency. Besides that, the mold contains impurities and other chemicals scientists haven't even identified, let alone analyzed, yet.

Does NORMBL care about these distinctions? Heavens no. Already losing the decrim fight, NORMBL starts spreading the word that it's bread mold, rather than synthetic penicillin derived from it, that gives strep throat patients relief. NORMBL begins lobbying state legislatures to legalize bread mold for medical purposes, and in the space of two years, 24 states legalize bread mold for strep throat patients.

Meanwhile, government officials who are responsible for approving any experimental drug for widespread distribution to the public, announce that there is now enough evidence to warrant producing synthetic penicillin pills for all strep throat patients. And you know what NORMBL does? NORMBL attacks the government for depriving strep throat patients of bread mold and trying to pass off synthetic penicillin, *which NORMBL calls a poor chemical substitute.* What we have to remember here is that once penicillin hits the market, and strep throat patients all over the country begin to get the relief they need, NORMBL will no longer have any reason to push for legal bread mold.

LET'S GET SERIOUS

Now, we've had fun with these analogies to prove a point, but it's time to get serious. We are talking here about cancer patients — not strep throat patients, about marijuana and THC — not bread mold and penicillin, about NORML — not NORMBL. Very few of us would do anything to deny relief to cancer patients suffering from the hideous side effects of chemotherapy, which is one reason NORML has been so successful in its cruel and exploitive campaign. To

COMMISSIONER'S REGULATIONS*

SECTION 135.1 DEFINITIONS

(e) Health education is instruction in understandings, attitudes and behavior in regard to the several dimensions of health. This instruction relates to alcohol, tobacco and other drugs, safety, mental health, nutrition, dental health, sensory perception, disease prevention and control, environmental and public health, consumer health, first aid, and other health-related areas.

SECTION 135.3 HEALTH EDUCATION

(a) Provision for health education. It shall be the duty of the trustees and boards of education to provide a satisfactory program in health education in accordance with the needs of pupils in all grades. This program shall include, but shall not be limited to, instruction concerning the misuse of alcohol, tobacco and other drugs.

(b) Health education in the elementary schools. The elementary school curriculum shall include a sequential health education program for all pupils, grades K-6. In the kindergarten and primary grades, the teacher shall provide for pupil participation in planned activities for developing attitudes, knowledge and behavior that contribute to their social and emotional, as well as physical, health. Personal health guidance shall also be provided according to the individual needs of pupils. This guidance shall include the development of specific habits necessary to maintain good individual and community health. In addition to continued health guidance, provision shall be made in the school program of grades 4, 5 and 6 for planned units of teaching which shall include health instruction through which pupils may become increasingly self-reliant in solving their own health problems and those of the group. Health education in the elementary school grades shall be taught by the regular classroom teachers.

(c) Health education in the secondary schools. The secondary school curriculum shall include health education as a constant for all pupils. In addition to continued health guidance in the junior high school grades, provision shall also be made for a separate one-half year course. In addition to continued health guidance in the senior high school, provision shall also be made for an approved one-half unit course. Health education shall be required for all pupils in the junior and senior high school grades and shall be taught by teachers holding a certificate to teach health. A member of each faculty with approved preparation shall be designated as health coordinator, in order that the entire faculty may cooperate in realizing the potential health-teaching values of the school programs. The health coordinator shall insure that related school courses are conducted in a manner supportive of health education, and provide for cooperation with community agencies and use of community resources necessary for achieving a complete school-community health education program.

* Rules of the Board of Regents and Regulations of the Commissioner of Education. Chapter II Commissioner's Regulations, Subchapter G. Part 135, Section 133.1 (e), Section 135.3 EFFECTIVE MARCH 20, 1978.

§ 804. Health education regarding alcohol, drugs and tobacco abuse

1. All schools shall include, as an integral part of health education, instruction so as to discourage the misuse and abuse of alcohol, tobacco, and other drugs and promote attitudes and behavior that enhance health, well being and human dignity.

2. Instruction regarding alcohol, tobacco, and other drugs shall be included in the health education provided for all elementary school pupils and shall be taught by the regular classroom teachers or by teachers certified to teach health education. Such instruction shall be designed according to the needs and abilities of the pupils at successive grade levels with the purpose of developing desirable health behavior, attitudes, and knowledge as well as self-reliance and problem solving capacity.

3. Instruction regarding alcohol, tobacco, and other drugs, in addition to continued health guidance in the junior high school grades and the senior high schools, shall be an integral part of a required health education course at each of these levels in the secondary schools curriculum. Any such course shall be taught by teachers holding a certificate to teach health. Related courses in the secondary school curriculum shall be taught in a manner supportive of health educaion regarding alcohol, tobacco, and other drugs.

4. The commissioner may prescribe in regulations such health education courses which include instruction regarding alcohol, tobacco, and other drugs as he may deem necessary and desirable for the welfare of pupils and the community. The contents may be varied to meet the needs of particular school districts, or portions thereof, and need no be uniform throughout the state.

5. School authorities shall provide the needed facilities, time, and place for the instruction set forth herein and shall provide learning aids and curriculum resource materials which contribute to effective teaching methods and learning in health education regarding alcohol, tobacco, and other drugs.

6. All pre-service training programs in the state for elementary teachers shall include adequate preparation regarding the instruction in alcohol, tobacco and other drugs set forth herein, and no teacher shall be licensed except upon satisfactory demonstration of the compentencies included in the institutional proposals approved by the education department.

7. Nothing contained in this section shall be deemed to diminish or impair the duties of the commissioner with respect to the continuing program for critical health problems established by chapter seven hundred eighty-seven of the laws of nineteen hundred sixty-seven as amended. The commissioner shall coordinate actions taken under authority of this section with the provisions of said chapter as they relate to health education in schools, in-service training and training programs, and curriculum or syllabus development regarding the deleterious effects resulting from the use, misuse, and abuse of alcohol, tobacco, and other drugs.

Added L 1977, c. 982, §1

Effective Date. Section effective July 1, 1977, pursuant to 1.1977, c.982, §2.

Derivation. Former sections 80 and § 1, and repealed by .1977, c.982 § 1, Said former section 804-a was added L.1952, c.413, §2, and repealed by L. 1977, c. 982, §1.

804-a. Said former section 804 was added L.1947, c. 820, §1; amended L.1952,c.413,

§ 804-a. Repealed L.1977, c.982, §1,eff. July 1, 1977 Section which related to instruction regarding the nature and effects of narcotics and habit-forming drugs was added L.1952, c.413, §2. The subject matter is now covered by section 804.

§ 805. Enforcement

1. On satisfactory evidence that any teacher has willfully refused to teach such subjects, as provided in sections eight hundred four and eight hundred four-a, the commissioner of education shall revoke the license of such teacher.

2. No public money of the state shall be apportioned by the commissioner of education or paid for the benefit of any city school district of a city having one hundred twenty-five thousand inhabitants or more according to the latest federal census until the superintendent of schools therein shall have filed with the treasurer or chamberlain of such city an affidavit, and with the commissioner of education a duplicate of such affidavit that he has made thorough investigation as to the facts, and that to the best of his knowledge, information and belief, all the provisions of sections eight hundred four and eight hundred four-a have been complied with in all the schools under his supervision in such district during the last preceding legal school year.

3. No public money of the state shall be apportioned by the commissioner of education or by district superintendents, or paid for the benefit of any school district, including city school districts of cities having less than one hundred twenty-five thousand inhabitants according to the latest federal census, until the president of the board of education, or in the case of common school districts the trustee or any member of the board of trustees, shall have filed with the district superintendent having jurisdiction or, in the case of such a city school district, or other district having its own superintendent of schools, with the commissioner of education, an affidavit that he has made thorough investigation as to the facts and to the best of his knowledge, information and belief, all the provisions of sections eight hundred four and eight hundred four-a have been complied with in such district, which affidavit shall be included in the trustees' annual report.

4. It shall be the duty of every district superintendent to file with the commissioner of education an affidavit in connection with his annual report, showing all districts in his jurisdiction that have and those that have not complied with all the provisions of sections eight hundred four and eight hundred four-a, according to the best of his knowledge, information and belief, based upon a thorough investigation by him as to the facts.

5. No public money of the state shall be apportioned or paid for the benefit of any school mentioned herein until the officer having jurisdiction or supervision thereof shall have filed with the commissioner of education an affidavit that he has made thorough investigation as to the facts and that to the best of his knowledge, information and belief, all the provisions of sections eight hundred four and eight hundred four-a relative thereto have been complied with.

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6. The principal of each state teachers college and state college for teachers in the state shall at the close of each school year file with the commissioner of education an affidavit that all the provisions of sections eight hundred four and eight hundred four-a applicable thereto have been complied with during the school year just terminated and until such affidavit shall be filed no warrant shall be issued by the commissioner of education for the payment by the treasurer of any of the money appropriated for such school.

7. It shall be the duty of the commissioner of education to provide blank forms of affidavits required herein for use by the local school officers, and he shall include in his annual report a statement showing every school district which has failed to comply with all the provisions of sections eight hundred four and eight hundred four-a during the preceding school year.

8. On complaint by appeal to the commissioner of education by any patron of the schools mentioned in sections eight hundred four and eight hundred four-a or by any citizen that any provision of such sections has not been complied with in any city or district, the commissioner of education shall make immediate investigation, and on satisfactory evidence of the truth of such complaint, shall thereupon and thereafter withhold all public money of the state to which such city or district would otherwise be entitled, until all the provisions of such sections shall be complied within said city or district.

L.1947, c.820; amended L.1952, c. 413 § 3; L.1953, c. 878, § 2, eff.
April 30, 1953

Historical Note

Subd. 1 amended L. 1952, c. 413, § 3, eff. July 1, 1952.

Subds. 2 and amended L. 1952, c. 413, § 3; L.1953, c.878, § 2, eff. April 30, 1953.

Subds. 4-6 amended L.1952, c. 413, § 3, eff. July 1, 1952.

Subd. 7 amended L.1952, c. 413, § 3; L. 1953, c. 878, § 2, eff. April 20, 1953.

Subd. 8 amended L.1952, c. 413, § 3, eff. July 1, 1952.

Derivation. Education Law of 1910, § 691, amended L.1930, c. 487, § 18. Similar provisions were contained in Education Law of 1909, § 761, derived from Consolidated School Law of 1894, c. 556, tit. 15, § 20, amended L. 1895, c. 104, § 1; L.1896, c. 901, § 1; originally revised from L.1884, c. 30, § 2.

Note of Commission of 1947 Revision. --Section revised; former § 691; first sentence of subd. 1 transferred to § 804 as subd. 7; reference to "this article" corrected to specify section in view of merging of articles; "district superintendent" substituted for "school commissioner"; reference to "normal schools" corrected; two minor changes in phraseology; surplusage in section heading omitted; reference to teachers' training classes and teachers' training classes and teachers' institutes omitted as obsolote.

Library References

Schools and School Districts 132.

C.J.S. Schools and School Districts § 165.

IMMUNITY FOR REPORTING DRUG ABUSE

§ 3028-a. Students under twenty-one years of age suspected of narcotic addiction.

Any teacher, school administrator, school guidance counselor, school psychologist, school drug counselor, school nurse, supervisor of attendance, attendance teacher or attendance officer having reasonable cause to suspect that a secondary or elementary student under twenty-one years of age is a substance abuser or substance dependent, who reports such information to the approproate secondary or elementary school officials pursuant to the school's drug policy or if the student under twenty-one years of age shall have immunity from any civil liability that might otherwise be incurred or imposed as a result of the making of such a report. Added L.1971, c. 1101; amended L.1972, c. 594, § 1.

1972 Amendment. L.1972, c. 594 S 1, eff. Sept. 1, 1972, added school guidance counselors, school psychologists, school drug counselors, and school nurses to the enumeration of personnel enjoying immunity from civil liability which might otherwise be incurred or imposed as the result of reporting information concerning suspected drug addiction or dangerous drug influence in students under 21.

ARTICLE 55 -- REGULATIONS BY BOARDS OF EDUCATION OF CONDUCT ON SCHOOL DISTRICT PROPERTY (NEW)

Sec.
2801. Regulation by boards of education of conduct on school district property.

§2801. Regulation by boards of education of conduct on school district property.

1. The board of education, as defined in section two of this chapter, of every school district, however created within the state shall adopt rules and regulations for the maintenance of public order on school property and shall provide a program for the enforcement thereof. Such rules and regulations shall govern the conduct of students, teachers and other staff as well as visitors and other licensees and invitees. The penalties for violations of such rules and regulations shall be clearly set forth therein and shall include provisions for the ejection of a violator from school property and in the case of a student or teacher, his suspension, expulsion or other appropriate disciplinary actions. Such rules and regulations shall be filed with the regents and the commissioner of education not later than ninety days after the effective date of this act. All amendments to such rules and regulations shall be filed with the regents and the commissioner of education not later than ten days after their adoption.

2. If the board of education fails to file the rules and regulations within the time required by this section such school district may not be eligible to receive any state aid or assistance until such rules and regulations are duly filed.

3. Nothing contained in this section is intended nor shall it be construed to limit or restrict the freedom of speech nor peaceful assembly.

Added .1972, c. 740, § 1.

Effective Date. Section 2 of L.1972, c. 740, provided that this section is effective September 1, 1972.

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
ALBANY, NEW YORK 12234

COORDINATOR
OFFICE OF DISTRICT ORGANIZATION
HEALTH AND PUPIL SERVICES

DIVISION OF SCHOOL HEALTH AND PUPIL PERSONNEL SERVICES
518-474-5807

BUREAUS OF:
DRUG EDUCATION: 474-1492
GUIDANCE: 474-6943
SCHOOL HEALTH EDUCATION AND SERVICES: 474-1491
SCHOOL PSYCHOLOGICAL AND SOCIAL SERVICES: 474-2066

QUESTIONS AND ANSWERS ABOUT EDUCATION LAW, SECTION 804 (1977)
Health Education Regarding Alcohol, Drugs and Tobacco Abuse

1. **/QUESTION/** At what grade level should alcohol, drugs and tobacco education begin?

   /ANSWER/ At the kindergarten level. Instruction at this level would be less content-oriented with objectives designed to develop a positive self image; acknowledgement and understanding of feelings; skills in making decisions and solving problems; social and emotional coping skills; and a sense of responsibility appropriate to the developmental level of the child.

2. **/QUESTION/** How can content areas be constructively addressed with primary grade children?

   /ANSWER/ Primarily, with an attitudinal and behavioral focus. Particularly important would be discussions and activities concerning how the body works and how it reacts to the things we do to it; what to do when offered something strange to eat or drink by someone and why; and what to do in various situations involving medicines and poisons. Important concepts would include: alcohol and cigarettes can make people sick; drugs can make sick people well and well people sick; cigarette smoke is a form of pollution hurting people who do not smoke as well as those wh do; among others.

3. **/QUESTION/** How many minutes should health education regarding alcohol, drugs and tobacco abuse be taught? What proportion of the health education program should be concerned with the alcohol, drugs and tobacco area?

   /ANSWER/ In determining priority and emphasis for drug education programs several matters should receive serious consideration. The nature and extent of community health problems and the needs of the school population should be foremost considerations. A needs assessment developed with the involvement of parents, student and community health professionals is recommended as a starting point. Most districts will find that problems in alcohol, tobacco and drug abuse and misuse are in the forefront of community issues concerning young people. Also, a good case can be made for addressing problems with vandalism and delinquency, other highly ranked issues, through some of the same affectively-oriented teaching methods used in preventing drug problems. Some of these methods should certainly be used on a very regular basis, if not every day.

4. **/QUESTION/** How can we add this new material to the elementary curriculum with the present constraints on time?

/ANSWER/ The drug education curriculum lends itself well to integration with other classroom subjects. The key is to design lessons in other areas, such as math, reading, social studies, art, and science, around drug education objectives and content. The new alcohol curriculum contains some integrated subject matter activities which may be used as models for this approach. Drug education activities for developing coping and decision-making skills and a positive self image can have important effects on pupil achievement in all curricular areas.

5. **/QUESTION/** What materials does the State Education Department provide to help schools implement Education Law 804?

/ANSWER/ Last year an extensive new curriculum for alcohol education, grades K through adult, was distributed to schools. In the spring of 1978 a selective new Annotated Resource Guide for the Elementary Level will be delivered to building principals and school librarians. Schools may order additional copies of these for classroom teacher use. A secondary level guide is now being planned. A hands-on curriculum for tobacco education is being developed for grades K-12 with help from the American Lung Association. For schools struggling with the development of local drug abuse policies, the 1970 Guidelines for School Programs in the Prevention of Drug Abuse is still available and not significantly outdated. During 1978 guidelines will be developed for school smoking policies. Also, Strand II Sociological Health Problems (1967), a section of the comprehensive New York State Health Education Curriculum, contains some still appropriate concepts and activities for grades 4-12.

6. **/QUESTION/** What resources are available for inservice training in drug education for teachers?

/ANSWER/ Community agencies such as the American Lung Association, American Cancer Society, American Heart Association, Councils on Alcoholism, and Drug Abuse Prevention Councils offer many services to teachers. In most communities it is possible to arrange for a program of teacher inservice through the cooperative efforts of school staff, representatives from these agencies and other community health professionals. Health Systems Agencies and teacher training institutions also provide help in some areas of the State. The new State Alcohol Education Curriculum includes an instructors guide for adult education programs - another valuable resource.

7. **/QUESTION/** Does Education Law 804 apply to non-public school programs? Do the Commissioner's Regulations for Health Education apply to non-public schools?

/ANSWER/ Yes, both apply to all schools, at kindergarten through high school levels.

2. Students seeking drug related help or advice from school personnel shall be informed of the availability of professional help and the rights of minors to seek help.

2.1 A staff member may report such an accident to or request advice from the school counselor or nurse.

2.2 The students should be fully informed of services that are available, their rights to receive the service and of the confidentiality to which they are entitled. The student should be encouraged to seek such help.

2.3 The teacher involved in such circumstances is obligated to guard the confidentiality of the student.

2.4 There is no need for disciplinary action in this situation.

2.5 Parents or any individual, excepting the nurse and counselor, may not be notified without written consent of the student.

2.6 Law enforcement involvement is not warranted in this situation.

Comment: All staff should be informed about their rights and responsibilities in this situation. Too often fear of liability prevents a staff member from becoming involved. Accurate information and referral procedures should be provided to all staff members.

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3. Occasionally, a student will contact a staff member in regard to the drug usage of another student. Any response must be made in consideration of the indirect source of the information. Such a student should be encouraged to relay information about help and students' rights to the student with the problem.

3.1 Such information will generally be maintained on a one to one basis, although the school counselor or nurse may be contacted.

3.2 The student who contacts a staff member should be encouraged to try and get the student with a problem to personally contact someone who can help.

3.3 The confidentiality of such information is the responsibility of the staff member who has been contacted. No contact further than the school nurse or counselor should be made.

Comment: It must be remembered that a student who discusses a "friend" may be looking for help himself. Staff should be aware of this possibility and the likelihood that they are being tested as a source of help. A positive approach is important. A familiarity with appropriate responses could be helpful.

4. When a student is suspected of possessing or using drug substances, yet there is no clear evidence to support the suspicion, a concerned staff member may offer help based on a personal concern for the well being, behavior or school performance of the student, NOT DRUG USE.

4.1 Investigation of such a suspected situation is limited to the staff member contacting the school counselor or nurse.

4.2 The student should be informed of available help and encouraged to seek assistance.

4.3 The suspecting staff member is obligated to guard such suspicions.

4.4. Discipline is not warranted in this situation.

4.5 Parents may only be notified by the counselor or school nurse, as last resort for getting help for such students. The notification shall be limited to behavioral problems, not suspected drug use.

4.6 Law enforcement involvement is not warranted.

Comment: Although there exists ambiguity about how far a school can go in this situation, these recommendations take into consideration the strong potential for misinterpreting a student's behavior as actual drug use. This error can easily be made about students who are "known" users.

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5. In instances of suspected possession or use that is confirmed by the student's admission to school personnel, school staff shall make every effort to pursue all possible approaches to have the student accept help.

5.1 Investigation will be limited to discussion between the staff member and student.

5.2 It is the staff member's responsibility to inform the student of the help that is available and the student's right to such help.

5.3 The staff member shall be responsible for the confidentiality of such discussions. A staff member may discuss the situation only with the nurse or counselor, preferably with the student's permission. No other contact should be made either to parents or law enforcement authorities.

Comment: Again there is some leeway in how a school may respond in this situation. It is recommended that effort be made to persuade the student in a positive manner to discuss his drug use with an appropriate professional.

6. In an instance of a student being caught with possession for the first time, the matter will be pursued on an internal basis in terms of investigation and discipline.

6.1 Investigation will be conducted by the principal or his authorized delegate. The staff member who discovers the drug will confiscate all drugs in plain sight. The students involved will be brought to the principal. The principal will then request that all other substances be surrendered. The principal shall search a student's locker in the presence of a second staff member. Students shall not be left alone during this process. If necessary, police authorities may be contacted to conduct a personal search.

6.2 Help will be provided through an appointment with a school drug counselor.

6.3 Confidentiality shall be the responsibility of the staff members involved. Distribution of information will be limited to student, staff member involved, school counselor, nurse, principal and superintendent.

6.4 Discipline will consist of a supervised inhouse suspension of 6 days, requiring completion of all regular school work in an area isolated from other students.

6.5 Parents shall be notified and completely informed of the circumstances.

6.6 Law enforcement authorities will be contacted so the school can turn over the drug substances. Student's name will be withheld.

Comment: We recommend against prolonged absences from school as it may contribute to the individual's increased involvement with substance use. It may be that the school will be the most effective agent to discipline the individual. Many alternative disciplines are possible including: special study projects, peer group programs, on-to-one counseling and group counseling sessions.

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7. In an instance of a student caught with possession repeatedly or who responds with arrogance, the matter will be pursued on an internal basis in terms of investigation and discipline.

7.1 Investigation will be conducted by the principal or his authorized delegate. The staff member who discovers the drug will confiscate all drugs in plain sight. The students involved will be brought to the principal. The principal will then request that all other substances be surrendered. The principal may search a student's locker in the presence of a second staff member. Students shall not be left alone during this process. If necessary, police authorities may be contacted to conduct a personal search.

7.2 Help will be provided through a mandated appointment with school drug counselor.

7.3 Confidentiality shall be the responsibility of the staff members involved. Distribution of information will be limited to student, staff member involved, school counselor, nurse, principal, superintendent and school board members.

7.4 Discipline will consist of a mandatory formal hearing before the school board consistent with all aspects of due process requirements. Further disciplinary action will be the decision of the board.

7.5 Parents shall be notified and completely informed of the circumstances.

7.6 Law enforcement authorities will be contacted so the school can turn over the drug substance. Student's name will be withheld.

Comment: This recommendation is made with the idea that in certain areas the school remains the best option for disciplining the student. Sometimes a diploma may be one of the few incentives a student may have for modifying his drug use.

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8. In an instance of a student volunteering information about possible drug possession or use, the situation will be investigated and necessary procedures will be followed.

8.1 Investigation of volunteered information will be conducted by the staff member contacting the principal, school drug counselor or school nurse for substantiation.

8.2 Confidentiality will be the responsibility of the staff member involved. Distribution of information will be limited to the student, staff member, school counselor, nurse, principal and superintendent.

Comment: It is preferred that information be considered in terms of providing help to a student who needs it rather than catching someone in the act. There is indication that the school's intent to prosecute an individual if caught may alter the rules under which investigations may be carried out. Reasonable cause may become necessary instead of reasonable suspicion.

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9. When a student has been caught with drugs and it is suspected that the student is selling or dispensing the drug, the situation will be investigated and all necessary procedures will be followed.

9.1 Investigation will be conducted by the principal or his authorized delegate. Because of the severity of this situation, extreme care should be exercised during all investigation. If available information indicates, the student will be questioned by the principal who will request the surrender of all substances. The principal shall search a student's locker in the presence of a second staff member.

9.2 Help will be provided through a mandated appointment with a school designated drug counselor or referral to appropriate drug and alcohol programs.

9.3 Confidentiality will be the responsibility of the staff members involved. Distribution of information will be limited to the student, staff involved, school counselor, nurse, principal, superintendent and school board members.

9.4 Discipline will consist of a mandatory formal hearing before the school board consistent with all aspects of due process requirements. Further disciplinary action will be the decision of the board. Legal authorities will be notified and informed of such instances resulting in possible legal action.

9.5 Parents will be notified as soon as adequate supportive information is collected.

9.6 Law enforcement authorities will be notified in such instances.

Comment: In situations such as this, it becomes more important that staff and students know their rules, rights and responsibilities. written guidelines may serve well to reduce anxiety and confusion for all parties involved.

* *

10. In instances of suspicion of a non-student selling or dispensing drugs on school property, the situation will be investigated and all necessary procedures will be followed.

10.1 Investigation will be the primary responsibility of the school principal with full cooperation from all school staff members.

10.2 Law enforcement authorities will be provided with all information.

Comment: Clear directions for handling such information will greatly improve the likelihood of effectively handling the situation.

Searches

It is clear that schools and school staff have the right to conduct searches in certain circumstances. A search may be conducted based on considerably less evidence than required by the police especially when the search is to protect the health, welfare and safety of the children and the educational process. School officials fulfilling their duties will not be held to the same standards as are law enforcement officials.

A clear situation in which a school may conduct a search is the school's right to search a student's locker. Lockers are the property of the school and the school has an obligation to insure that they are used properly. However, it is strongly recommended that schools have a clearly written locker policy, as well as a written policy regarding all searches. These policies should be explained and disseminated to the students.

Simply stated, the more private the object is that is to be searched, the more evidence there is required to conduct that search.

In all cases there should be clear school policies regarding searches. Permission of the student should be requested. All searches should be conducted in the presence of another staff member and the student, if possible.

Key Things to Remember

1. Know the facts; do not act upon hearsay or vague suspicion.
2. Your jurisdiction is directly related to the extent of your responsibility.
3. The confidentiality of students is protected by law.
4. Schools should have a special relationship with local police. This relationship may dictate the effectiveness of a school policy.
5. Individual rights are balanced in regard to the general welfare. Every effort should be exerted to maintain this balance.
6. Schools may conduct warrantless searches but only according to specific guidelines, and under very defined circumstances. See your solicitor for guidance.
7. Minors have the right to counseling, information and treatment without parental notification.
8. "Regulations on students' rights and responsibilities" provides important information regarding school discipline procedures.

CONSIDERATIONS FOR CONDUCTING SEARCHES

1. Warrantless searches should be conducted only upon the basis of reasonable suspicion that the student is concealing something, possession of which is either in violation of the law or of school rules. Normally, this suspicion would be specific to the studnet being searched.

2. Voluntary disclosure of the suspected property, or consent to make the search, should be sought before commencing an involuntary search. Consent is only meaningful in court if it is elicited without coercion or threat.

3. The basis for suspicion sufficient to be "reasonable" increases in direct proportion to the amount of interference with privacy of the student(s) involved. The justification for a personal search of the person must be far greater than that required for search of a school locker.

4. The danger presented by the property being sought, the student's age and record of conduct, and the urgency of making the search without delay are all circumstances bearing on its reasonableness.

5. The primary purpose and justification should be the protection of the health, safety and welfare of students, faculty, school property and the educational process. Arrest and prosecution for violation of criminal law should only be a subsidiary result of any warrantless search.

In the present state of the law, adherence to these principles should result in evidence which is admissable in school disciplinary proceedings and any criminal prosecution or juvenile court proceeding which might result from its surrender to law enforcement authorities. Hopefully, following these rules will also demonstrate a sufficient attempt to respect the Fourth Amendment rights of students as to protect principals and other administrators against the threat of civil rights suits.

WHAT TO DO IF YOU CONFISCATE A SUBSTANCE

In our various contacts with school personnel, we have become aware of the questions regarding the proper procedure for drug confiscations within a school or district.

We would recommend the following procedure as it protects you, the administrator - as well as the particular student and his rights.

1. Never accuse any student of possession or use of a drug.

2. Any confiscated sample should be placed in an envelope. A witness should be present.

3. The following should be noted on the outside of the envelope:

    a. date and time
    b. school name
    c. description of contents (i.e., leafy vegetable matter, pill, capsule - do not guess at labeling.)
    d. signature of both parties

4. SEAL THE ENVELOPE - To insure proper sealing, use scotch tape.

5. The school official should call a local law enforcement agency such as State Police (specific juvenile officer) or local police agency.

6. At this time, you may indicate that there is a sample to be analyzed and the proper authorities would pick it up. (You do not have legal immunity if you keep possession of a drug. Always turn it over to someone who is authorized to dispose of the substance.)

    YOU DO NOT HAVE TO INDICATE THE STUDENT'S NAME.

7. Have the official receiving the sample open it in your presence and witness that you did indeed deliver the indicated sample. It would be helpful to have him sign the envelope too.

8. Request that they advise you as to the results of the sample after analyzation.

9. Should you decide to take action - whether legal or administrative - you will have followed a procedure that protects your rights as well as those of the student.

SEARCH AND SEIZURE*

As you know, school authorities have broad discretion with respect to the search of student lockers (People v. Overton, 24 NY 2d 522). However, their freedom is much more limited with respect to the search of a student's person.

As former Chief Judge Breitel of the Court of Appeals has said with respect to the matter of individual rights, on the one hand, and the necessity for security and order in the public schools on the other, "The ultimate issue is one often faced in the law: the balancing of basic personal rights against urgent social necessities, a balancing always fraught with difficulty, strain and niceness of distinctions." (People v. Scott D., 34 NY 2d 483). In that case, the Court held that evidence obtained in a personal search based on a mere suspicion of possible drug possession must be suppressed. The general rule is that there must a reasonable basis for a personal search. The Court held in Scott D. that neither prior suspicious conduct on the part of the student nor imprecise information allegedly provided by a "confidential source" were sufficient to warrant a search and seizure.

That decision has been distinguished by the Court of Appeals, however, from a case where information that a given student was selling narcotics on school premises was provided by a student informant, who had furnished the dean with similar information on five prior occasions, in each of which the information provided by the student had led to the discovery of narcotics. In that case, the Court of Appeals held that there was a sufficient basis for a search and seizure (People v. Singletary, 37 NY 2d 310).

As might be expected, the federal courts have also dealt with the matter of searches and seizures in the public schools. In M.M. v. Anker, 607 F. 2d 588 [1979], the Second Circuit held that while the unique relationship between teachers and their students justifies somewhat greater flexibility in determining whether there is a reasonable basis for a search and seizure, as the "intrusiveness" of the search intensifies the standard of Fourth Amendment "reasonableness" for the search approaches the requirement of a finding that there was probable cause for the search.

And Judge Munson of the Northern District of New York has held that where there was no basis for knowing which of the students in the fifth grade class might have stolen three dollars from one of their classmates, it was unlawful to conduct a strip search of the entire class (Bellnier v. Lund, 438 F. Supp. 47).

Judge Hughes of the Supreme Court, Rensselaer County, has summarized the search and siezure rules in these words.

"It is settled in New York that when a public school official searches a student such search must comport with the requirements of the Fourth Amendment. . . . The justification required for the warrantless search of a student is much less than the usual criminal standard of probable cause . . . However, some reasonable suspicion of wrongdoing related to the individual student must exist before a search can be conducted . . . A mass search of lockers is permissible . . ., but a dragnet search of the entire student body without reasonable cause for suspecting each individual student is not . . . " (Gentner v. East Greenbush Central School district, ______ Misc. _______[December 20, 1978].

Guidelines For Emergency Medical Procedures

A variety of health emergencies have appeared in some schools as a result of the non-medical use of drugs by students. Those engaged in such practices frequently do not know the size dosage or can even identify the substances ingested or injected. Life-threatening situations may develop through overdoses and mistaken use of substance.

In view of these conditions, it is well to review the related duties and constraints imposed upon school personnel by law. As employees of boards of education, school nurse-teachers, school nurses, teachers, and other school employees are responsible for first aid care of school children who are injured or become ill while under school supervision, whatever the source or cause of the emergency. (Education Law Article 19, Sec. 912; Commissioner's Regulations Sec. 136.3. Available from Bureau of Health Education and Services, New York State Education Dept.)

First aid is treatment intended to protect the life and comfort of a child until authorized treatment is secured and is limited to first treatment only, following which the child is to be placed under the care of his/her parents, upon whom rests the responsibility for securing subsequent treatment. Boards of education, as corporate bodies, are not authorized to provide medical or dental care, beyond first aid, regardless of how worthwhile such services may be to the individual child.

Internal medication should not be administered even in emergencies to any child by the school personnel other than a physician who has seen and prescribed

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* From inside education, New York State Education Department, Nov.-Dec., 1080 p. 26-27.

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for that particular case. The school emergency procedures for children of employees suffering from drug related emergencies should follow school district policy and State Education Department guidelines (School Health Emergency Program, 1980).

A SUSPECTED DRUG EMERGENCY SHOULD BE TREATED LIKE ANY OTHER MEDICAL EMERGENCY -- DO NOT ASSUME DRUGS TO BE THE PROBLEM.

Every school should have planned, written policies for emergency care. Such policies should be developed through cooperative efforts of the school physician, school nurse-teacher, parents, and the school administrator. Such a program of emergency care should include provisions for:

1. Written instructions in simple first aid procedures to guide those providing emergency care. These should be developed by the school physician and school health services staff to guide school personnel in the administration of first aid. Mimeographed copies, bearing the signature of the school physician should be placed in each classroom, shop, gymnasium, and similar work areas.

2. Current written directions for reaching parents without undue delay should be available. These should include the telephone number of the parent or guardian, name and telephone number of the family personal physician, and the name of a relative or friend who would assume responsibility when the parent or guardian is not available.

3. Plan for transporting pupils home or to a source of medical attention. Such plans are the joint responsibility of the school authorities and the parents. In cases of extreme emergency, when school personnel are unable to reach a parent other persons designated by the parent as indicated above, the school, which is acting in place of the parent, is responsible for transporting the child to the source of medical attention.

4. Arrangements for the services of physicians when needed for emergency care. Ordinarily, the school physician would be responsible for such emergency care. In the event of his absence, arrangements should be made with other physicians in the area to provide medical care in emergencies.

Inspection of Lockers

People v. Overton

The question frequently arises as to the right of school officials on their own volition or in conjunction with police officers to conduct an inspection of students' lockers. In People v. Overton, it was held that a student's possession of a school locker is not exclusive against the school or its officials. The court said:

A school does not supply its students with lockers for illicit use in harboring pilfered or harmful substances. We deem it a proper function of school authorities to inspect the lockers under their control and to prevent their use in illicit ways or for illegal purposes. We believe that right of inspection is inherent in the authority vested in school administration and that the same must be retained and exercised in the management of our schools if their educational functions are to be maintained and the welfare of the student bodies preserved.

Search of Student's Person

United States v. DiRe, 332, U.S. 581; State v. Bradbury, 243A 2d 302; People v. Cohen, 57 Misc. 2d 366.

While the inspection of a locker, with or without a warrant, is permissible, the rule is otherwise with respect to the search of the individual. To search an individual unless the search is the incident of a lawful arrest and not the mere occasion which gives rise to the arrest, a search warrant should be obtained. School authorities should refrain from searching individual students, or requiring the emptying of pockets or removal of clothing. The same would apply to a student's automobile parked in a student parking lot.

Confidentiality

Matter of Thibadeau, 1 Ed. Dept. Rep 607; VanAllen v. McCleary, 27 Misc. 2d 81 (Nassau County Supreme Court); Manual on Pupil Records, Chapter II.

The Laws of the State of New York provide statutory protection for the confidentiality of disclosures between professionals and clients including priests, physicians, dentists, nurses, attorneys, certified psychologists, and social workers in the scope of their private professional practices--but there is no such statutory protection for confidential communications made to school employees such as psychologists (unless certified), social workers, guidance counselors, or others.

The Commissioner of Education has held in a judicial proceeding that all pupil personnel records are confidential as far as third parties are concerned, with the school and the parent being the first and second parties.

LEGAL CONSIDERATIONS

In view of the complex nature of this matter, the following section is only a brief description of some areas of legal implications for consideration as you take on the process of developing drug policy. Remember that laws and their interpretations change as a result of court decisions, and therefore, you should consult with your school attorney regarding all aspects of your drug policy.

The establishment of an educational program requires rules and regulations designed to maintain an orderly program and to operate the school in a manner conducive to learning.

School authorities have always been bound by the requirement that their rules and regulations be reasonable. On review by the commissioner or the courts, consideration is given primarily to the question whether such rules and regulations are a reasonable exercise of the power and discretion vested in those authorities.

It is the duty of school authorities to insure the protection of the educational system and the students. To fulfill this duty, school authorities have been given the power to discipline those students who, due to their conduct or their physical or mental condition, are disrupting the educative process or are endangering the health, safety, or morals of themselves or of others (education law, section 3214).

During the process of policy development the following questions may arise:

1. Are school authorities required, as a matter of law, to report suspected or established drug abuse by a student to the parent(s) or legal guardian(s)?
2. Are school districts prohibited, as a matter of law, from giving such advice to parents?

There currently exists no statutory provision which either requires or prohibits such communication to parent(s) or legal guardian(s). Hence, the determination whether such a report ought to be made is a matter of policy for local determination.

School officials have no authority to waive due process and legal rights of the student. Issues regarding the inspection of lockers, motor vehicles, search of the student's person are among the complex issues which require the advice of local legal counsels.

The student and parent(s) should be aware that school records include only data concerning school achievement results and attendance. School records do not include information concerning drug involvement (Federal Register, Vol. 41, No. 118, Thursday, June 17, 1976).

CONFIDENTIALITY

Trust is a crucial issue in creating and maintaining an atmosphere for the positive utilization of human resources. The professional, para-professional relationship is potentially one of the most promising instruments in effecting attitude and behavior changes with a drug-involved youth.

In order to observe the rights of those in a counseling relationship, when a person comes to the counselor for help, the counselor will help the individual understand that information within the school setting cannot always be kept confidential; in some cases it will be referred to the appropriate individual or agency. These cases will include those that endanger the welfare of the student or others. This information is subject to disclosure in a court of law. At this time there is no law in New York governing counselor-student confidentiality.

The student should be aware that school records include only data concerning school achievements, test results, and attendance. School records do not include information concerning drug involvement. (See law on school records.)

The laws of the State of New York provide statutory protection for the confidentiality of disclosures between professionals and clients including priests, physicians, dentists, nurses, attorneys, certified psychologists, and social workers in the scope of their private professional practices -- but there is no such statutory protection for confidential communications made to school employees, such as psychologists (unless certified), social workers, guidance counselors, or others.

The commissioner of education has held in a judicial proceeding that all pupil personnel records are confidential as far as third parties are concerned, with the school and the parent being the first and second parties (Matter of Thibadeau, 1 Ed. Dept. Rep. 607). The same result was reached by Nassau County Supreme Court in Van Allen v. McCleary, 27 Misc. 2d 81. (See also the Manual on Pupil Records, Chapter II.) These decisions, however, do not deal with information relating to knowledge of commission of crimes by students.

APPENDIX A
SAMPLE POLICY STATEMENTS

Sample Policy I: Paper Products Manufacturing Company

The Company recognizes that if behavioral/medical problems (alcoholism, drug dependencies, addictions, and emotional disturbances) are diagnosed and properly treated before the persons reach the advanced stages, a high percentage of the cases can recover. It is also recognized that because such problems are often misunderstood and mishandled by the persons, their families, employers, and also by professional or therapeutic facilities, potential recovery opportunities are missed.

It is the purpose of this policy, and of the control measures the company utilizes to implement it, to provide a basis for in-plant action regarding behavioral/medical problems in a manner which will:

-- Encourage the earliest possible diagnosis, treatment, and other appropriate help in all situations where employee health and work performance have been affected.

-- Assure consistency in neither providing more help nor condoning more delay in seeking help than would be the general in-plant practice in comparable situations involving non-stigmatized illnesses, and

-- Coordinate in-plant and community-helping services so that, insofar as possible, employees seeking help can benefit from the best combination of helping and therapeutic services appropriate to various behavioral/medical conditions and available within the community.

The decision to seek diagnosis and accept treatment for any illness is the responsibility of the individual. It will be the company's policy that the same individual responsibility applies to behavioral/medical problems, since the company views these as treatable illnesses insofar as personnel administrative practices are concerned. Further, it will be the responsibility of the employee to comply with the referrals for diagnosis and to cooperate with the prescribed therapy. Unsatisfactory job performance will be handled under the rules pursuant to labor agreements covering union-affiliated employees and under rules of conduct covering other groups.

Sample Policy II: Computer Manufacturing and Marketing Company

APPROVED POLICY ON ALCOHOL AND DRUGS

Purpose. The company recognizes that the state of an employee's health affects his job performance, the kind of work he can perform, and may affect his opportunities for continued employment. The company also recognizes that alcohol and drug abuse ranks as one of the major health problems in the world. It is the intent of this policy to provide employees with the company's viewpoint on behavioral/medical disorders, to encourage an enlightened viewpoint toward these disorders, and to provide guidelines for consistent handling throughout the company regarding alcohol and drug usage situations.

Policy. The company intends to give the same consideration to persons with chemical (alcohol and other drugs) dependencies as it does to employees having other diseases. The company is concerned only with those situations where use of alcohol and other drugs seriously interferes with any employee's health and his job performance, adversely affects the job performance of other employees, or is considered so serious as to be detrimental to the company's business. There is no intent to intrude upon the private lives of employees.

Early recognition and treatment of chemical dependency problems is important for successful rehabilitation; economic return to the company; and reduced personal, family, and social disruption. The company supports sound treatment efforts, and an employee's job will not be jeopardized for conscientiously seeking assistance. Constructive disciplinary measures may be utilized to provide motivation to seek assistance. Normal company benefits, such as sick leave and the group medical plan, are available to give help in the rehabilitation process.

Legal Drugs (including alcohol).

1. The use of any legally obtained drug, including alcohol, to the point where such use adversely affects the employee's job performance, is prohibited. This prohibition covers arriving on company premises under the effects of any drug

which adversely affects the employee's job performance, including the use of prescribed drugs under medical direction. Where physician-directed use of drugs adversely affects job performance, it is in the best general interest of the employee, co-workers, and the company that sick leave be utilized.

a. Any employee engaging in the misuse of alcoholic beverages on company premises is subject to disciplinary action, up to and including termination.

Illegal Drugs.

1. Illegal drugs, for the purpose of this policy, include a) drugs which are not legally obtainable and b) drugs which are legally obtainable but have been obtained illegally.

2. The sale, purchase, transfer, use, or possession of illegal drugs, as defined above, by employees on company premises or while on company business is prohibited. Arriving on company premises under the influence of any drug to the extent that job performance is adversely affected is prohibited. This prohibition applies to any and all forms of narcotics, depressants, stimulants, or hallucinogens whose sale, purchase, transfer, use, or possession is prohibited or restricted by law.

   a. Any employee engaging in the sale of such illegal drugs on company premises or while on company business will be suspended immediately pending investigation.

   b. Any employee found purchasing, transferring, possessing, or using illegal drugs on company premises or while on company business is subject to disciplinary action, up to and including termination. It is the intent of the company, however, to encourage and assist such employees in treatment or rehabilitation whenever appropriate.

Scope. This policy is to be implemented in world-wide operations. Where legal or extralegal obligations or common business practices in International Operations conflict with the scope of this policy, the principles and intent of the policy should be followed as closely as possible.

Sample Policy III: Public Utility Company

The use of any drug interfering with safe and efficient function is a matter of company concern, and will be dealt with in an appropriate manner.

Alcohol is also a drug about which there is a serious concern. Its excessive use will be considered in the same manner.

The company recognizes that drug misuse may be a serious medical problem. A rehabilitation program is offered in the medical department. Employees cooperating in a clinically-supervised rehabilitation program may be eligible for benefits.

Possession or use of illegally obtained drugs on the job or on company premises may be a cause for dismissal.

EMPLOYEE ASSISTANCE

As drug policies are developed for students, there is also the need to develop drug policies relating to school employees.

An employer (school district) sets the tone for the development of a supportive environment and supportive relationship with its employees. This helping strategy which interfaces an employee with a supervisor prior to a job crisis can be referred to as constructive confrontation. It offers help and support toward resolution, rather than avoidance of human problems.

School employees are human, and should not be considered any less vulnerable or immune to human stress than any other professional. When school employees are faced with sudden crisis, or demonstrate impaired or deteriorating performance, or demonstrate self-destructive behaviors, an employer can and should intervene on the employees' behalf in a supportive manner.

The process is one of constructive confrontation. It is one of proactive or intervention measures made in the best interest of employees. Formulating a policy of employee assistance is an essential positive step in recognizing the need to encourage, provide mechanisms for, and make offers to help connect persons in need with positive support systems.

Our social system is served by distinguishing between youth and adults. In regard to the non-medical use of drugs, being more forceful with adults has historically been the norm.

Programs in education, business, industry and the military need to confront the issues of the non-medical use of drugs, including alcohol by employees at all levels. These programs need to be publicized and made readily available.

Both proactive and intervention type programs are equally important for employees. Employee-assistance programs have proven to be cost-effective and both employer and employee benefit in numerous ways.

The employer's right to intervene is based on two basic premises; first, a basic concern for the health and welfare of the persons whom they employ, second, the employer's right to expect quality job performance. These concerns can be acted upon when a policy is in place, is disseminated, and followed through.

Basic to these policies are the following:

- The employee is responsible for his/her actions;
- The employee is a role model for students;
- The employer is supportive of the employee in seeking help for problems;
- It is the employer's responsibility not to ignore employee problems;
- Constructive confrontation to make employees aware of opportunities and choices for help;
- Efforts to maintain confidentiality will be made by employers;
- The use of outside referrals to non-school personnel;
- Feedback on employee's progress;
- Training for supervisors in methods of constructive confrontation;
- Opportunities for self-referral;
- Preventive programs of normalization and mainstreaming of new employees;
- Dissemination of policy and implementation of proactive measures;
- A view of the policy as an employee benefit rather than a threat;
- Crisis precipitation for those who do not address problems;
- Clearly stated information regarding job penalties and losses for continued impaired performance.

EMPLOYEE ASSISTANCE PROGRAMS HAVE PROVEN COST AND HUMAN EFFECTIVE, AND APPEAR AS YET TO BE AN UNTAPPED RESOURCE IN EDUCATIONAL SETTINGS.

PATTERNS OF JOB PERFORMANCE DETERIORATION

Supervisors at all levels are in the best position to be aware of deteriorating job performance. The key words in relating to job performance problems noted below are continuing and repeated. If a pattern of work performance deterioration begins to appear with an employee who was formerly a competent and stable worker, you should pay close attention and document his specific work deficiencies.

1. Absenteeism — Generally, any excess absenteeism and increases in absenteeism should be noted. The following are some general patterns:
    a) Unauthorized leave.
    b) Excessive sick leave.
    c) Monday absences, Friday absences, or Monday and Friday absences.
    d) Repeated absences of two to four days.
    e) Repeated absences of one to two weeks, (five to ten days).
    f) Excessive tardiness, especially on Monday mornings or in returning from lunch.
    g) Leaving work early.
    h) Peculiar and increasingly improbable excuses for absence.
    i) Higher absenteeism rate than other employees for colds, flu, etc.
    j) Frequent unscheduled short term absences, (with or without medical explanation).
2. "On-the-Job Absenteeism"
    a) Continued absences from post — more than job requires.
    b) Frequent trips to water fountain or bathroom.
    c) Long coffee breaks.
    d) Physical illness on job.
3. High Accident Rate
    a) Accidents on the job.
    b) Frequent trips to nurse's office.
    c) Accidents off the job, but affecting job performance.
4. Difficulty in Concentration
    a) Work requires great effort.
    b) Jobs take more time.
    c) Excessive nervousness.
5. Confusion
    a) Difficulty in recalling instructions, details, etc.
    b) Increasing difficulty in handling complex assignments.
    c) Difficulty in recalling own mistakes.
6. Spasmodic Work Patterns — Alternate periods of very high and very low productivity.
7. Tenacity to Job - Doesn't Change Easily — Changes may present a threat, because his control of present job allows him to hide low job performance.
8. Generally Lowered Job Efficiency
    a) Misses deadlines.
    b) Makes mistakes due to inattention or poor judgement.
    c) Wastes more material.
    d) Makes bad decisions.
    e) Complaints from customers.
    f) Improbable excuses for poor job performance.
9. Employee Relations on the Job
    a) Over-reacts to real or imagined criticism.
    b) Wide swings in morale.
    c) Borrows money from co-workers.
    d) Complaints from co-workers
    e) Fighting with co-workers.
    f) Unreasonable resentments.
    g) Begins to avoid associates.

Remember: All employees, including supervisors, exhibit some of these job performance problems occasionally. It is a pattern of job performance problems over a period of time (several months), that should be noted and documented.

1. Do you feel you are a normal drinker?
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of that evening?
3. Do your spouse, parents, friends or others complain about your drinking or ask you to try to stop drinking?
4. Can you stop drinking without a struggle after one or two drinks?
5. Do you efer feel bad about your drinking?
6. Do friends or relatives think you are a normal drinker?
7. Do you every try to limit your drinking to certain times of the day or to certain places?
8. Are you always able to stop drinking when you want to?
9. Have you ever attended a meeting of Alcoholics Anonymous (A.A.)?
10. Have you gotten into fights when drinking?
11. Has drinking ever created problems with you and your spouse (or parents)?
12. Has your spouse (or other family member) ever gone to anyone for help about your drinking?
13. Have you ever lost frineds or girlfriends or boyfriends because of your drinking?
14. Have you ever gotten into trouble at work because of your drinking?
15. Have you ever lost a job because of your drinking?
16. Have you ever neglected your obligations, your family or your work for two or more days in a row because you are drinking?
17. Do you take medication? What kind? How often?
18. Do you or have you ever taken pills to settle your nerves or to sleep?
19. Do you have to take more now to settle down or sleep?
20. Where do you get your pills?
21. How long have you been taking them?
22. Have you ever lost a period of time - minute, hours, days - after taking pills or alcohol?
23. Have you ever tried to stop taking pills or stop drinking alcohol? Why?
24. Have you ever lost friends or family over drugs or alcohol?
25. Have your friends or family ever tried to get you to stop drinking or taking pills?
26. Has drinking or pills taking ever cost you a job or get you into trouble?

Is it possible...

. . . that someone you care about has
changed for no apparent reason?

From eager, active, enthusiastic
To passive, apathetic, hopeless

From friendly, open, trusting
To suspicious, antagonistic, alienated

From talkative, clear, expressive
To silent, confused, withdrawn

From dependable, helpful, attentive
To forgetful, vague, disinterested

From confident, poised, self-assured
To oppressed, tormented, persecuted

From vital, healthy, energetic
To nervous, up-tight, restless

From optimistic, cheerful, pleasant
To cynical, pessimistic, moody . . . ?

When someone claims drugs are the answer,
they may be the cause

EARLY INTERVENTION AND CONFRONTATION

1. Early Intervention

The following are strategies for intervention and confrontation that are most successful:

(A) Recognition. In most instances problem drinking by a student may manifest itself in these problematic behavioral areas:

- (1) Vandalism
- (2) Property damage
- (3) DWI or DWAI
- (4) Absenteeism from class
- (5) Frequent tardiness in class
- (6) Legal ramifications (with either security or the community police department)
- (7) Excessive partying (more than two or three times a week)
- (8) Low academic standing (if specifically documented by faculty)
- (9) Frequent public intoxication (in the classroom or during school activities)
- (10) Negativism (manifestation of extreme negative attitude towards environment, peers, or both may be an indication of a problem, or this attitude may lead to a problem)
- (11) Blackouts
- (12) Others ??

(B) Documentation - Documentation is essential when confronting a student who has exhibited problematic behavior due to the abuse of alcohol. Documentati must be specific and concise.

Example:

"On Friday, October 5th at 11:30 a.m., Bill Jones, a freshman, broke a window in room 331. First hand observations by a teacher, and other immediate students indicate that Bill Jones was in an intoxicated state Consequently, this disciplinary board has to invoke an optional referra to the Alcohol Awareness Program that has contractually agreed upon as a part of your student orientation."

(C) Confrontation - "Confrontation is an active combination of immediacy, empathy, and interpretation. It is an assertive statement by counselors or helpers, that is designed to help the clients crystallize their inconsistencies of expression and behavior. It is an encouragement to action."

- Bellikin (1975)

Confrontation too often connotes a negative criticism. Instead, I would like to think of confrontation as a positive alternative towards self-action on the part of the client: the statement, "I know where you can get help and I will take you there" is always helpful.

There are two different schemes of confrontation; first: One to one confrontation, and secondly: Group Confrontation or Crisis Intervention. Confrontation of the problem-drinking student should have the following form Meaningful or significant people must be present to state the specific facts of the Alcohol Related Problematic behavior. That is, these participants exert a real influence upon the problem drinker. For instance: (1) a clos personal friend or fellow student (2) the parents (3) a teacher, and (4) th High School Counselor (who should be there after confrontation for linkage into referral system).

When confronting the problem drinking student, the individual, or grou of individuals doing the confrontation should adhere to the following princi

(1) First hand observation is the best.

(2) Remain non-judgemental.

(3) Present only specific facts, nothing else!

(4) Be assertive when presenting.

(5) Don't over generalize.

(6) Stick to the alcohol-related incident or incidents. Remember, th goal of intervention and confrontation is to have the student see and accept enough reality so that, however grudgingly, he or she (in time) can accept their need for help.

(D) Last, but not least, is "The Offer of Assistance". When the confrontation has been made, the Offer of Assistance then plays a dominant role. It is at this point that empathetic understanding and concern must be forthcoming, although these characteristics, hopefully, have been present all during the confrontation.

Confrontation is a double-edged sword. It is a concise statement of the negative aspects of the alcohol-related abusive pattern, while concurrently suggesting a helping, caring attitude. Therefore, along with the act of confrontation is an offer of positive assistance: The referral component of the Early Intervention model.

THE FOLLOWING IS AN EXAMPLE OF A POLICY STATEMENT ADOPTED BY A BOARD OF EDUCATION:

Sample Board of Education Policy on Drug Abuse Prevention

The ____________________ School System has adopted the following Board of Education policy for the purpose of educating and protecting the school and community concerning the non-medical use of drugs. Alcohol shall be considered a drug when interpreting this policy. This policy includes drugs and alcohol on school property as well as school activities sponsored off school property.

Though this policy refers to drugs, it should not be considered a separate entity from other parts of the school program, for it is the responsibility of the school system to teach health education, aid in personal development, attitudes, and maintain proper discipline.

This policy provides for the education of the school and community concerning drug abuse prevention. It also forbids any pupil, employee or citizen to be under the influence, to use, to have in his/her possession, or distribute in anyway, drugs and alcohol on school property or school-sponsored activities off school property.

The need to educate and protect pupils and school employees, as well as others in the community whenever possible, should be accomplished through a variety of programs. These programs should include, though not necessarily be limited to, the following:

-- Education of pupils at all grade levels in accordance with state requirements as well as beyond where possible;

-- Counseling of pupils in groups and as individuals by appropriately trained and skilled school staff assigned for this purpose;

-- School staff pre-service and in-service education;

-- Parent education and counseling;

-- Community awareness/information programs;

-- Enforcement of school district policies and regulations along with existing laws;

-- Dissemination of accurate and necessary information;

-- Active participation by all school staff.

The superintendent of schools is responsible for the implementation of this policy and with his/her staff shall develop administrative regulations and procedures for implementation and dissemination. The regulations shall be reviewed by the board of education prior to their dissemination. Such regulations as well as this policy shall be reviewed annually by the board of education and the advisory groups that may be established in the area of drug abuse prevention.

In developing necessary regulations to implement this policy, at least the following shall be included pertaining to drugs and alcohol on school property or at school sponsored activities off school property:

-- The suspension or its alternative of any pupil or employee who after due process is considered by the building principal to be under the influence, in possession, or involved in the distribution of drugs or alcohol;
-- The use of law enforcement agencies to report such violations;
-- The use of proper medical personnel for health and safety;
-- The proper reporting procedure to parents when this policy is violated by pupils;
-- Active participation of all school staff in this effort.

The superintendent of schools is responsible to periodically report to the board of education violations of this policy.

THE FOLLOWING IS AN EXAMPLE OF AN ADMINISTRATIVE REGULATIONS STATEMENT:

FROM POLICY STATEMENTS, ADMINISTRATIVE RULES AND REGULATIONS ARE DEVELOPED. IT IS IMPERATIVE THAT POLICIES REFLECT CONSISTANCY. CHOICE OF WORDS IS HIGHLY IMPORTANT AND DIRECT ADMINISTRATIVE ACTION.

Sample Administrative Regulations on Drug Abuse Prevention

The ____________________ School System has established the following administrative regulations to implement the board of education policy on drug abuse prevention.

The superintendent of schools is responsible for the development, dissemination and implementation of these regulations.

The wording of regulations may be modified by principals and supports supervisors, with the approval of the superintendent, for dissemination to students and staff personnel. Likewise, principals and support staff supervisors are also responsible to the superintendent for dissemination and implementation of these regulations. Dissemination shall be included in, but not necessarily limited to, all student/parent handbooks and employee handbooks.

These regulations will be amended as necessary by the superintendent of schools and such amendments will be made available to the board of education. The board of education shall review these regulations annually.

I. Student Drug Use

Student involvement with drugs, including alcohol, on school property should be treated according to following procedures. It shall be the responsibility of school employees to report all reasonably suspected instances of the non-medical use of drugs to the principal or other administrator in charge.

1. Distribution or Selling of Drugs

Whenever the principal is reasonably certain that a student is involved in the distribution or selling of drugs, law enforcement authorities and parent(s) or legal guardian(s) shall be contacted.

If it has been determined that a student is involved in the distribution of drugs, he/she shall be suspended for five (5) school days and referred to the superintendent of schools for further action.

The superintendent will then conduct a hearing. Following the hearing, the superintendent may return the student to school, follow an alternative procedure, extend the suspension, or refuse his/her return indefinitely.

2. Possession of Drugs

Law enforcement authorites shall be contacted whenever the principal determines that drugs to be used for non-medical purposes are found in the possession of a student. The principal may also contact law enforcement authorities to help make such a determination. Pupils who are in the possession of drugs to be used for non-medical purposes shall be suspended for five (5) school days, or follow alternative procedures.

In the event that this is the second time that a student has been suspended for a drug related offense, he/she will be referred to the superintendent of schools for further action.

The superintendent will then conduct a hearing. Following the hearing, the superintendent may return the student to school, or extend the suspension, or refuse his/her return indefinitely, or follow alternative procedures.

Parent(s) or legal guardians shall be kept informed throughout the process.

3. Under the Influence of Drugs

Whenever there is reasonable suspicion of a student being under the influence of drugs, he/she should be referred to appropriate medical personnel.

If it has been determined he/she is under the influence of non-medical drugs, parental authorities shall be contacted. The student may also be suspended for five (5) school days.

In the event this is the second time that a student has been involved in a drug related offense, he/she will be referred to the superintendent of schools for further action.

The superintendent will then conduct a hearing. Following the hearing, the superintendent may return the student to school, or extend the suspension, or refuse his/her return indefinitely, or follow alternative procedures.

4. Student Who Seeks Help

The board of education does not condone the non-medical use of drugs. However, it does recognize the need for the availability of help to those who use/abuse drugs. Members of the professional staff desire to offer a helping relationship and referral when necessary. It is the position of the board of education that communications between students and professonal staff will be held in trust, unless it becomes evident that withholding information may result in harm or injury to the student and/or others. Staff persons must understand and recognize their personal and professional limitations and are encouraged to refer students to appropriate resources.

5. Involvement with Medical Drugs (medication)

Students who need to have access to medical drugs (drugs for medical purposes) in school should leave them with the school nursing personnel. Such drugs should be left with school nursing personnel along with parental permission and the written directions of a physician concerning their use. In case a student needs to use such drugs when a nurse is not on duty (or at a school sponsored event away from school property), at least a parental note should be given the supervisor on duty and the drug left with him/her except when needed.

Students who are in the possession of medically approved drugs but have not followed the directions described above shall be warned for the first offense. For succeeding offenses he/she should be disciplined according to normal school disciplinary policies not necessarily directly with these regulations.

Students who distribute such drugs to others will be considered under the policy as distributing drugs for non-medical purposes.

6. Parent Involvement

Whenever there is a reasonable suspicion that a student is suspected of violating the school drug policy and is questioned by the school principal or designee, his/her parents or legal guardian shall be notified.

Whenever it has been determined that a student has violated the school drug policy, his/her parents shall be notified immediately. Parent conferences are not only encouraged, but shall be required throughout any disciplinary procedures.

7. Medical Services

When there is reasonable suspicion that any person is under the influence of drugs while school is in session, he/she shall be referred to the school health services personnel. Such cases shall be treated like any other medical problem. The school health services shall report it to the principal.

When there is reasonable suspicion that any student/person is under the influence of drugs while at a school activity and no school health services are available, it shall be the responsibility of the supervisor on duty to call for appropriate aid.

8. Return to School

Whenever a student has been determined as using drugs for non-medical purposes and has returned after the appropriate suspensions, an effort should be made by school personnel and parent(s) or legal guardian(s) to keep the problem from occurring again. The process could include, but not necessarily be limited to, the following:

-- Community based programs;

-- Group or individual counseling for students and families;

-- An effort made by the student's teachers to help him/her emphasize the positive alternatives to drug using behavior.

However, any of the above activities should not be construed to mean that other disciplinary measures that accompanied the violation are to be ignored.

9. Student Neglect, Child Abuse or Child Maltreatment

There may be an occasion when a staff member believes that a parent or other adult is contributing to drug-using behavior of a student. The staff member should confer with the principal; however such a conference does not preclude the right of the staff member to refer the case to the appropriate child protective service for further investigation. (For further info refer to: article 6, Title 6, Social Services Law: sec. 412, 415, 419, 420.)

II. Student Education

Each principal shall see that drug abuse prevention (including alcohol, tobacco, and other drugs) is taught as part of a comprehensive health education program K-12 in district's curriculum. A primary goal of the program is to equip the learner for decisions they must make about drugs and their lives.

In addition to the established curriculum, each principal shall make use of other educational information including but not necessarily limited to, assemblies, speakers, printed materials, class discussions and bulletin board materials, and inclusion in other curriculum areas whenever possible.

A report of each building's activities toward the efforts of drug abuse prevention shall be reported to the superintendent annually by each principal.

VI. Student Counseling

Student counseling on drug use should be conducted by those counselors who have received proper training and demonstrate expertise in this area.

Drug counseling should emphasize prevention as well as treatment and therefore should make an effort to be available to all pupils who desire this service. Pupils shall be referred to a certified counselor.

Counseling should be done individually where necessary. Group counseling shall be employed when possible.

Whenever a student seeks out an employee, other than a trained counselor to discuss his/her problems, the particular staff member should make an effort to direct the pupil to appropriate counseling. However, if this seems to be unrealistic, the staff member should stay in regular contact with a trained counselor.

Trust between student and staff should be maintained as much as possible.* Student needs and the health and safety of the student and others are critical issues which should be addressed by all staff.

IV. Staff Education

Within the first 30 days of each school year, all principals and support staff supervisors will arrange a meeting that shall include information on drug abuse prevention. The program will be conducted by those personnel trained in the area and will include, but not necessarily be limited to, district policies and regulations, the identification of commonly used drugs, and a humanistic approach to deal with students.

Also, within two weeks after a new employee has been hired, he/she will receive similar information as part of their orientation process.

V. Parent and Community Education

At least once annually the school district will sponsor a program on its drug abuse prevention programs. In addition to presentations by the school staff, the program will include representatives of law enforcement agencies and the legal, medical and religious professions.

The district also will offer a program annually in parent effectiveness or other appropriate programs which involve parents.

School personnel may be requested to act as resource persons in the community. Release time may be approved through the superintendent of schools to serve in these capacities.

News releases and other forms of communications may be used to educate parents and the community using regular school channels for such purposes.

An advisory committee on drug abuse prevention made up of community representatives, parents, school staff, and students will meet at least twice annually to review the policy and procedures. However, the committee may meet as often as necessary to study the district's drug prevention program and make recommendations to the superintendent.

VI. Employee Drug Use

The non-medical use of drugs including alcohol is forbidden on school property or at school sponsored activities away from school property. Employees determined to be using such drugs shall be reported immediately to the principal or other persons in charge. The superintendent shall be notified immediately.

Upon notification, the superintendent shall conduct an investigation. He/She shall consult with the school attorney when necessary. If the results of his/her investigation show sufficient evidence that the employee is involved with the distribution, possession or is under the influence of such drugs, law enforcement authorities shall be notified.

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* See Legal Considerations and Confidentiality, P. 19-20.

However, if the employee is under the influence of alcohol, and not being disorderly, it shall not be necessary to notify law enforcement authorities.

Once it has been determined that the employee has violated the school drug policy, the superintendent shall suspend the employee until the next board of education meeting. The board may then determine disciplinary measures according to law.

Employees suspected of being under the influence of drugs for non-medical purposes should be reported to appropriate school health services personnel as well as other school authorities. If it is determined that "being under the influence" is due to the use of drugs for non-medical purposes, the above procedures shall be followed. If "being under the influence" is due to the use of drugs on medical purposes an employee/employer conference shall take place in order to clarify the situation.

When an employee is believed to be using drugs for non-medical purposes away from school property as well as [illegible] high degree of alcohol, the principal and/or superintendent shall make an effort to confidentially discuss the matter for the purpose of helping the individual. (See Employee Assistance.)

VII. Citizen Drug Use

In addition to students and employees, citizens of the community visit and use the schools. The use of drugs for non-medical purposes including alcohol is forbidden. Persons distributing, possessing or under the influence of such drugs shall be reported to the principal or the person in charge.

If the principal or person in charge has determined such a violation has occurred, or he/she is reasonably certain it has occurred, law enforcement authorities shall be contacted.

However, if an adult is under the influence of alcohol, but not disorderly, good judgement shall prevail and the person shall be removed from the property.

A person may be barred from school property by the superintendent if he/she has violated the school drug policy, including alcohol, and it is a second offense.

SAMPLE STATEMENT FOR STUDENT HANDBOOKS

The drug policy of the district should be included in a student handbook either in whole or as an abridged version. It is recommended that those parts of the policy directly related to students should be included in the handbook.

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PUTNAM NORTHERN WESTCHESTER
BOCES
LINKING LOCAL SCHOOL DISTRICTS AND THE STATE THROUGH SERVICE

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A MODEL DRUG POLICY

WITH GUIDELINES AND BACKGROUND INFORMATION

BY: KENNETH L. PACKER
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Developed September 1974

A PHILOSOPHY OF DRUG ABUSE PREVENTION

The school has an ethical and legal obligation to assist students to grow in knowledge and understanding of themselves and their environment so as to produce the insights needed, and ability to make critical decisions.

To help prevent drug[1] and alcohol abuse the school shall develop a comprehensive health education program that deals with human feelings, human experience and factual knowledge.

Specifically, the following goals should provide a basis for the schools approach to problems related to drug abuse:

a) To involve youth in all phases of the program in order that they may identify with its purpose, may provide relevant information, and may be aware that it is for the enhancement of, not the control of, their lives;

b) To teach decision making as a process and to provide opportunities for development of this skill;

c) To provide students with opportunities to clarify their values, select life goals, evaluate alternatives for personal life style and learn to enjoy life;

d) To furnish factual information in an unbiased manner so students can make intelligent decisions regarding drugs and their lives;

e) To counsel and when appropriate refer students with problems to outside agencies;

f) To monitor and attempt to eliminate the flow of drugs in the school, for the protection of all students;

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1. The term "drug" as used throughout, means the same as "dangerous drug" as defined in the New York State Penal Law, see page 9 . The term includes marijuana.

g) To cooperate with those agencies, groups and individuals in the community who also have a role in dealing with drug abuse and its related problems;

h) To provide information to parents about all aspects of the program and involve them, where appropriate, so they can be supportive and be part of the prevention team;

i) To motivate people to assume a personal responsibility for the behavior of their peers and thus help them adopt positive views of self-worth and avoid self-destructive courses of action;

j) To present viable alternatives to the use of chemical substances as a crutch.

EDUCATION PROGRAM

Policy I:

The District shall develop a drug, alcohol, and smoking education program as part of the total comprehensive health education program[2]. A primary goal shall be to equip the student for decisions he must make about drugs and his life.

Guidelines:

a) Inservice training will be provided for teachers in the area of prevention, education, and counseling, so that they will be adequately prepared to teach about drugs, alcohol, and tobacco.

b) Instructional materials will be purchased for this area and will be considered high priority items.

c) The school district shall make its educational facilities and resources available for adult education in the area of health and drug education.

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[2] Commissioner's Regulations: Subchapter G, Part 135, Section 135.5

Policy II:

A district-wide Health Coordinator is to be appointed who will take charge of the entire health education program and act as a resource person to teachers who are not health education specialists.[3]

COUNSELING AND REFERRAL

Background:

The key concern or guiding principle in handling information about drug use by students should be the welfare of the student concerned. School staffs should treat information about drug use among students with the most careful confidentiality. If a school staff member releases such information to other persons without the permission of the student involved, this will likely destroy the school's reputation for responsible treatment of information and cut off communication with most pupils with problems. When a pupil admits he is using drugs this should normally be considered privileged information. However, students should be encouraged to seek their parents' and other assistance.

Policy III:

Students who reveal to professional staff members that they have been or are involved in the personal use of drugs or narcotics and students who turn in drugs or narcotics to staff members for disposal shall have the con-

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[3] Commissioner's Regulations: Subchapter G, Part 135, Section 135.5

confidentiality and anonymity of their communications fully respected.

Guidelines:

In order to guide those persons, such as teachers, counselors, administrators, or the psychological staff, to whom drug-using youth may turn, the following points need clarification:

1) When drugs or narcotics are voluntarily turned in to any staff member, the material shall be given to the principal or assistant principal without the names of the students involved. The principal shall dispose of it by giving it directly to the police or to the District Health Coordinator, who shall give it to the police. The student's confidentiality and anonymity shall be maintained during this procedure.

2) Once a youth has confided to the professional, the relationship is strongly guided by the policy of confidentiality. This may limit the professional in seeking guidance and advice from other staff professionals or community officials. Therefore, the professional should make clear the degree of anonymity the student wishes established so that the professional may describe the problem to a more knowledgeable professional for more experienced guidance. The youth and the professional should therefore mutually define the scope of confidentiality before the professional seeks other assistance.

3) Although students shall have the confidentiality of their communications fully respected by staff members, the best

interests of the health of the individual student shall dictate any action taken by a staff member. That is to say that a staff member shall not refuse to disclose information to medical authorities at any time a student's life or health may be in immediate danger.

4) A major purpose of confidentiality shall be to create an atmosphere of trust, encouraging the youth to seek future personal involvement with his parents, appropriate school personnel, or a community drug staff worker. The less-trained or less-experienced professional should, without breaching confidentiality, explain his professional deficiencies and his wish to seek the aid of more skilled professionals in this matter.

5) The school professional (the teacher, the counselor, the administrator and the specialist) should understand his own limitations in order to assess correctly a youth's condition (mental or physical) and the depth of use. Without the ability to assess, the school professional is lost in seeking appropriate avenues of counseling and/or treatment. The school professional may simply serve a communications function to an alienated youth, whereby friendship and trust can help a youth pass through a troubled time. However, where follow-through, evaluation or treatment are indicated, the professional must seek knowledgeable guidance from more experienced professionals.

6) Within the limits of confidentiality, the school professional should first consult the District Health Coordinator who will

inform the teacher of the various resources available in the district for assistance. The teacher will then inform the student of these resources and will allow the student to seek the help he chooses.

7) The intent and limits of confidentiality -
It is not the intention of a policy on confidentiality to protect students who are delibertly breaking the law by selling and pushing drugs on school grounds. These students should be caught and turned over to the police. It is the intent, however, of this policy to protect the student who is actively involved in some kind of a counseling relationship and who is working towards becoming drug free.

STUDENTS SUSPECTED OF DRUG USE

Policy IV:

Students suspected of drug use should be confronted with the suspicion by the School Nurse-Teacher, the District Health Coordinator, or any other staff member. If the suspicion is correct, the student should be encouraged to get involved into a confidential helping relationship with an appropriate counselor.

Guidelines:

Students admitting to drug involvement use should be handled under the guidelines of Policy Statement III.

If under extreme situations (for the health of the person), it is deemed necessary to test students for suspected drug use, pupils may be required to submit to a urine analysis test with the consent of their parents[1],

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4. Education Law, Section 912-a

This, however, is not recommended as a normal procedure because of its detrimental effect on the trust level in the school.

Any school staff member is protected by immunity from civil liability when reporting or confronting suspected drug abuses, as long as the report was made with good intention and good reason for suspicion.[5]

STUDENTS UNDER THE INFLUENCE

Policy V:

Pupils who exhibit symptoms of being under the influence of drugs, or alcohol while in school, or by their own admission reveal that they are under the influence of drugs, narcotics or alcohol, shall be received by the school nurse-teacher, or the school nurse-teacher shall be brought to the student. No student shall be sent to the nurse's office unattended. The student's emotional and physical state shall be evaluated by the school nurse-teacher, who shall be in consultation with the school doctor if such action is judged to be necessary.

If there is reasonable doubt concerning the welfare of the student in terms of his needs for immediate care as evaluated by the nurse-teacher and the doctor, the parent will be notified and the case treated as any other emergency.

If the student appears to be in no danger, but is obviously under the influence of a drug, he shall remain in the medical office under careful observation and supportive concern until he is able to return to normal activity. If the student has not recovered normalcy by the end of the school day, professional staff members shall use their judgment on how to get the student home.

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[5] Education Law, Section 3028-a

Guidelines:

Confidentiality in terms of releasing information to administrators, parents, and police will be determined by the factors involved in each individual situation. Where it is felt to be in the best interests of the individual, he shall be given the same benefits of confidentiality as provided for in the guidelines of Policy Statement III. The judgment of the school nurse-teacher shall determine the appropriate action to be taken in each situation, and she may avail herself of the advice and consultation of other professional staff members, including administrators, counselors, psychologists, and school doctors.

In the event that a student, who is obviously under the influence of a drug, is taken home by a staff member, a physician's statement indicating that the student is fit to return to school shall be presented to the school nurse-teacher before the student may be re-admitted. Students taken home should be left in the custody of their parents and not left by themselves.

POSSESSION OR SALE OF DRUGS

Policy VI:

Staff members who apprehend students in the possession or sale of dangerous drugs while in school or on school grounds shall take the student to the principal's office. He shall make every effort to notify the parents of the student. The police will be notified by the school's principal.

Guidelines:

Establishing a trust relationship among students and between students and staff and parents must be considered in attempting to control the drug traffice within schools, but it cannot be permitted to work to the detriment of efforts to control the flow of drugs. Schools cannot stand idly by while one youth with a problem projects that problem on his fellow students. Any youth who is suspected of distributing or pushing drugs on school property should be investigated. Appropriate action should be taken by the school to prevent the drug flow and if necessary involve legal authorities to apprehend the distributor or pusher.

One method of getting information on drug traffic is through search of lockers. The law in regard to the right to search a student and/or his locker is not clear, and therefore school administrators should obtain legal advice before undertaking such a search. School locker searches for drugs, even where they may be legal, frequently reveal little or no information; thus, should only be conducted after serious study.

As defined in Section 220 of the New York State Penal Law, "sale" is defined as to sell, exchange, give or dispose to another or to offer or agree to do the same.

As defined in the New York State Penal Law, dangerous drugs include:

a. Narcotic drugs (e.g. heroin, morphine, opium, any opium derivative, or cocaine).

b. Depressants (barbituates)

c. Stimulants (amphetamines)

d. Hallucinogenic drugs (e.g. LSD, marijuana, STP, DMT, Peyote)

Appendix C

STATE OF NEW YORK

S. 1968—C

A. 2746—C
Cal. No. 270

1979-1980 Regular Sessions

SENATE–ASSEMBLY

February 6, 1979

IN SENATE—Introduced by Sens. JOHNSON, ACKERMAN, BERMAN, BRUNO, DUNNE, FARLEY, GALIBER, HALPERIN, LACK, LEICHTER, MENDEZ, NOLAN, OWENS, PADAVAN, RUIZ, TRUNZO, WEINSTEIN—read twice and ordered printed, and when printed to be committed to the Committee on Health—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

IN ASSEMBLY—Introduced by M. of A. GRANNIS, HEVESI—Multi-Sponsored by—M. of A. ABRAMSON, BARBARO, BIANCHI, COOPERMAN, D'AMATO, D'ANDREA, DelTORO, ENGEL, EVE, FINNERAN, GOTTFRIED, GRIFFITH, HARENBERG, HINCHEY, HIRSCH, HOCHBRUECKNER, HOWARD, JACOBS, KENNEDY, KIDDER, KISOR, KOPPELL, LAFAYETTE, LEHNER, MARCHISELLI, MONTANO, NADLER, NEWBURGER, PAROLA, PASSANNANTE, PESCE, PILLITTERE, PROUD, RETTALIATA, ROBLES, SANDERS, SEMINERIO, SERRANO, SIEGEL, STAVISKY, STRELZIN, E. C. SULLIVAN, F. M. SULLIVAN, P. M. SULLIVAN, TALLON, VANN, S. P. WALSH, WERTZ, YEVOLI—read once and referred to the Committee on Health—reported and referred to the Committee on Codes—committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee—reported from said committee with amendments, ordered reprinted as amended and placed on the order of second reading—advanced to a third reading, amended and ordered reprinted, retaining its place on the order of third reading

AN ACT to amend the public health law, in relation to protecting the public health, comfort and environment by prohibiting smoking in public places and at public meetings except in designated smoking areas and to repeal article thirteen-F of such law relating thereto

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Legislative findings and purpose. The legislature hereby finds that tobacco smoke is one of the major health hazards present in our environment.

EXPLANATION — Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

There is substantial scientific evidence that tobacco smoke causes cancer, heart disease and various lung disorders. The legislature further finds that the harmful effects of tobacco smoke are not confined to smokers, but also cause severe discomfort and in some cases grave illnesses to non-smokers, who constitute a growing majority of the adult population. It is therefore the purpose of this legislation to protect and preserve in a reasonable manner the health and comfort of the people of this state by creating in places that are visited by the general public areas that are free from the toxic and nuisance effects of tobacco smoke.

§ 2. Article thirteen-F of the public health law is **repealed.**

§ 3. Such law is amended by adding a new article thirteen-F to read as follows:

ARTICLE 13-F

CLEAN INDOOR AIR

Section 1399-o. Definitions.
1399-p. Prohibition.
1399-q. Designation of smoking areas.
1399-r. Smoking in elevators prohibited.
1399-s. Responsibilities of proprietors.
1399-t. Local regulations.
1399-u. Violation.

§ 1399-o. Definitions. For the purposes of this article, the following terms shall have the following meanings:

1. "Bar" means a place at which the principal business is the sale of alcoholic beverages for on-premises consumption, or that area of the restaurant which is devoted primarily to the sale or serving of alcoholic beverages.

2. "Place of work" means any indoor area in which two or more persons are employed for wages or salaries or render volunteer services, excluding factories and exceptions as defined in subdivision nine of section two of the labor law and private enclosed offices occupied exclusively by smokers even though such offices may be visited by non-smokers.

3. "Restaurant" means a place in which the principal business is the sale of food for on-premises consumption.

4. "Smoking" includes the burning of a lighted cigar, cigarette, pipe or any other matter or substance, which contains tobacco.

5. "Smoking areas" means a designated area in which smoking is permitted.

6. "Indoor areas open to the public" shall include but not be limited to restaurants, retail stores, public means of mass transportation, all schools, colleges and universities, hospitals as defined by article twenty-eight of the public health law, auditoriums, theaters, libraries, museums, arenas and meeting rooms.

§ 1399-p. Prohibition. No person shall smoke in any place of work or any indoor area open to the public except in designated smoking areas. This prohibition shall not apply when an entire room or hall is used for a private social function and arrangements are under the control of the sponsor of the function and not the proprietor or manager of the room or hall.

§ 1399-q. Designation of smoking areas. 1. Smoking areas may be designated by proprietor or other persons in charge except in areas where smoking is prohibited by the fire marshall or other law, ordinance or regulation. Where smoking areas are designated a sign shall indicate their location and existing physical barriers and ventilation systems shall be used to minimize the effect of smoke in adjacent non-smoking areas.

2. The following areas may be designated as smoking areas in their entirety:

a. a bar;

b. a place of work or any indoor area open to the public with less than one thousand square feet of floor area;

c. a restaurant which seats one hundred or less persons; provided, however, that if there is more than one dining area in such restaurants it is the intent of this law to encourage the proprietor to preserve one of such areas as a non-smoking area. In the case of any restaurant or bar designated as a smoking area in its entirety, the proprietor or person in charge must post a sign so stating this designation. This sign must be posted clearly so as to be visable to the public before or as they are entering the premises;

d. a restroom; and

e. an area commonly referred to as a lobby.

§ 1399-r. Smoking in elevators prohibited. Notwithstanding any inconsistent provision of this article or any other law, ordinance or regulation, no person shall smoke in any elevator accessible to the public.

§ 1399-s. Responsiblities of proprietors. If a smoking area is designated, the proprietor or other person in charge shall post signs pursuant to this article.

§ 1399-t. Local regulations. Nothing contained in this article shall be deemed to limit the authority of a city, town or village from adopting or amending local laws which provide stricter regulation of smoking in places of work and indoor areas open to the public.

§ 1399-u. Violation. Any person who violates the provisions of this article shall be guilty of a violation punishable by a fine of not more than twenty-five dollars for the first violation and not more than one hundred dollars for each successive violation.

§ 4. This act shall take effect on the first day of January next succeeding the date on which it shall have become a law.

REPEAL NOTE.—Article thirteen-F of the public health law, proposed to be repealed by this act, makes it unlawful to smoke tobacco in any public means of transportation and in any indoor facility such as a library, museum or theater. It would be replaced by a new article thirteen-F relating to the same subject, and expanding thereupon.

D-23

MEMORANDUM

TO: Mr. Hawley
FROM: Jeanette Dippo
DATE: June 17, 1981
RE: Proposed Comprehensive School Smoking Policy

I. Rationale

A. The Cortland Junior-Senior High School Smoking policy is based on educational goals and practices designed to:

1. Discourage the unsafe and unhealthful practice of smoking consistent with research findings and education and public health laws.
2. Address the needs of all types of groups found in the school setting in order to:
    a. Reinforce the non-smoking behavior of those who have not begun smoke.
    b. Assist those who already smoke and wish to stop.
    c. Provide a smoke free environment for those who must have it due to the presence of allergy or disease.
    d. Provide as safe and appropriate an environment as possible for those who, given all the facts, make the personal decision to smoke.

II. School's position

A. For students: No smoking whatsoever is allowed anywhere within the school building. The outside area for student smoking, centrally located at the island between the parking lot and driveway, is available for use before school, during the lunch periods, and after school. No smoking is permitted at this location between regular class periods. The outside is to be used ONLY by students 16 yrs. of age or older who are in possession of their parental permission card. To obtain this card, the student must sign up for a parental permission form which will be mailed home with an explanatory letter and is to be mailed back to the student's house principal. A permission card will be issued to the student only after a follow-up phone call to the parent/guardian confirms the signature. No smoking is allowed on school busses, in cars parked in the school parking lot during school hours, during fire drills, bomb scares, or any other situation involving emergency evacuation of the school building.

B. For staff: Faculty smoking is to be prohibited except in designated areas. In addition, no faculty member is allowed to smoke in the presence of students before, during, or after school, or in any role as supervisor or coach of after-school activities and athletics. The same rules apply to non-instructional staff who may smoke only in those areas designated by the administration.

C. For visitors: Visitors may smoke only in designated areas. No smoking is allowed in the building by visitors to any school program or indoor athletic event. Those adults who wish to smoke at school programs may use the main entry-way between the two sets of double doors.

III. Containment and enforcement

A. Although smoking is hazardous to one's health, the discipline outlined in this policy is in response to violation of the rules and not violation of one's health.

B. Any adult staff member who discovers a student in violation of these rules is to escort that student to the main office for an immediate meeting with the student's respective house principal. Any evidence discovered should be brought along, also.

C. The principal will enforce the appropriate disciplinary measures for the student involved.

D. Disciplinary measures are designed to be consistent with supervisory regulations and responsive to individual rights and due process:

1. For students: For a first offense, violators will attend a smoking cessation program and may also be assigned in-school suspension for one day. For a second offense, the student will be given three days in-school suspension. A third offense will involve a five day in school suspension. Beyond the third offense, a Superintendent's conference must take place. For all first time violators of this smoking policy, attendance is required at a corrective smoking clinic.
2. For staff: Staff violators will receive a warning on the first offense and be encouraged to attend a smoking cessation program. A second offense will involve a written letter of reprimand and a third offense is grounds for insubordination.
3. For visitors: Any visitor to the school who violates this smoking policy will have the policy explained to him/her and be requested to act accordingly. Any person who persistSin violating the policy despite this explanation will be requested to leave the premises. Failure to do so will result in the summoning of local law enforcement officials to escort this person off school property.

AMERICAN LUNG ASSOCIATION, HUDSON VALLEY, INC.

35 Orchard Street, White Plains, New York 10603/Headquarters
124 Green Street, Kingston, New York 12401/Area Office

BLUEPRINT FOR A HIGH SCHOOL SMOKING CESSATION CLINIC

Introduction

In any smoking prevention program, young people are often given scientific and medical facts to help convince them that smoking is injurious to their health. This, we anticipate will plan an important part in their decision making.

Where health educators have been doing a good job in smoking education, young people who are convinced are now saying, "You have convinced us that smoking is detrimental to our health, now tell us how to kick the habit."

The Approach

Once we are certain that the young people we are to work with in a smoking cessation clinic have the basic facts concerning health and smoking, we then add another facet. They need to know certain facts about human motivations and behavior that result in the formation of habits.

Though all smokers have many things in common that lead to and reinforce their desire to smoke, there are individual problems that must be dealt with. Thus it is necessary to provide an opportunity for individual counselling.

The School Approach to Smoking Cessation Clinics

Basic Requirements

1. The students must come voluntarily.
2. School time must be made available - approximately one hour for each of the three sessions, one week apart.
3. The student must be willing to take an active part in discussions and in the required reading.
4. The student must be willing to sign the Smoker's Pledge.*

Session I

1. Students are given a brief questionnaire to fill out to determine their smoking habits.
2. A brief film (Emphysema) is shown to reinforce the concept that smoking is injurious to one's health.
3. Literature on the dangers of smoking is distributed to each student as required reading for future discussions.

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*Included with Blueprint.

BLUEPRINT FOR A HIGH SCHOOL SMOKING CESSATION CLINIC

4. Printed tips on how to quit smoking are made available with a request that students mark off those they could live with and could follow as their first step towards kicking the habit.

5. Students are asked to announce to friends and relatives and whoever will listen that they are giving up smoking. Such a commitment is important.

6. A signed pledge card must be given to someone who really wants to see the student kick the habit. The student is required to report daily on his progress to this person.

Session II

The clinic leader starts an informal discussion going by asking students to discuss the progress they made that week or the problems they had encountered.

The students then are asked if there was anything in the literature they read that they want to talk over.

Students are asked to discuss the reaction of their parents and friends to their announcement that they are kicking the habit.

Each student is invited to tell which tips are working for them or if they have any original ideas that are helpful, to given them to the group.

Session III - Panel Discussion

Students who have kicked the habit "cold turkey" or have appreciably cut down on their smoking by the third session are asked to serve as panelists.

Students who by their own admission have not made any progress are asked to tell of their problems and efforts to the panel.

The panelists along with the leader will try to analyze the difficulty and make suggestions that might be helpful in light of their own experience.

Those who are off the cigarettes will relate their physical and mental reactions to the others and how they coped. This encourages those who have not fully taken the step and will assist in allaying their fears about not being able to endure withdrawal.

As a final step, students are asked to give a target date at which time they hope to totally abstain from smoking to the holder of their pledge card.

Students are also requested at the end to give a progress report to the teacher or nurse sponsor of the clinic.

The final request of the clinic leader is that all participants start to think as nonsmokers. They are given lapel buttons to wear that say "Thank You For Not Smoking" and a printed sign for their room at home which gives the same message. Most important, they are to crusade for nonsmoking by trying to convince all others who will listen that smoking is a bad habit, a life shortener, detrimental to physical fitness and the pursuit of happiness.

A SMOKER'S PLEDGE

I pledge this day to make an honest effort to break my smoking habit. I further pledge that each morning I will set forth the number of cigarettes I will smoke and abide by it until the target date, at which time I will stop smoking completely.

I do this in the interest of protecting my good health - a most precious asset.

____

Signature

(FRONT)

Benefits of Kicking the Habit

I will breathe easier.
I will feel less tired.
My sense of taste and smell will improve.
It will reduce my chances for a heart attack and lung cancer.
It will contribute to a longer and healthier life.

(BACK)

To Smoke Or Not To Smoke

by Ira Freedman

When Mum and Dad were young the words of a certain pop tune proclaimed: "You've got me in between the devil and the deep blue sea," while today's generation sums up the situation with the expression "Catch-22."

Both might be used in talking about the dilemma of smoking by youth, a problem familiar in many communities. On one hand there is evidence that smoking is tied to lung cancer, emphysema, and heart disease. Thus cigarette packages warn the smoker, TV advertising of cigarettes is outlawed, and schools include units of study on the deleterious effects of tobacco.

On the other hand one finds colorful and high-powered newspaper and magazine advertisements featuring virile, athletic male smokers and sexually attractive female smokers. Couple this with the nation's teenagers who are rapidly turning from boys into men and from girls into women and then add the time-honored practice of kids' wanting to act like grownups. A dilemma can result.

What are the schools of New York State doing? Continuing the traditional, unconditional ban on smoking or easing up and sanctioning a reasonable amount of smoking on school premises? The answer is both!

Sampling of Districts

In Liberty, one district that prohibits smoking, attempts of a small group of students to secure a smoking area failed a year ago due to lack of enthusiasm by the majority of their

POLICIES PERMITTING

Brighton. Smoking is prohibited during the school day, except for students who have smoking permission cards, signed by their parents, on file in the assistant principal's office. For those with parental permission, smoking is limited to a prescribed area before and after school, and during the student's lunch mods. Smoking is not permitted during unstructured time. Violation of smoking regulations results in suspension.

Burnt Hills-Ballston Lake. Students who wish to smoke must have a Smoker's Identification Card to be shown as requested to teachers or student supervisors. A fee is charged to cover the cost of the card. It should be visible when the student is using a smoking area.

Smoking is limited to prescribed areas, between classes only. Students are not expected to remain in smoking areas for entire periods.

A student committee shall be formed from those holding smoking cards. Three students from the group shall be designated as supervisors; each block will work with on-duty teachers to maintain clean and orderly conditions. They will assist as needed in identifying violation of rules.

First offense means choice of assignment to a room for that period for one week or five periods of clean-up work in building or on grounds. For the second offense, student is assigned to supervised study hall for all free time for two weeks. Third offense loss of all free time for one semester, at least one month. "Smoking" is interpreted as possession of lighted smoking material, or obvious intent to do so. Failure to complete any of these penalties is treated as insubordinate conduct.

East Aurora. Smoking by students is prohibited within district school buildings at any time, but student smoking may be permitted on school property by the superintendent of schools in areas designated by the building principal. Each violation of this policy will result in suspension for no more than five school days.

POLICIES FORBIDDING

Olean. Students are not permitted to smoke in the school building or on school grounds.

Suspension will be issued to any student caught smoking in the school building or on adjacent school grounds.

Jamestown. In accordance with fire prevention regulations, smoking in school buildings is not permitted, except for adults, who may smoke in rooms designated by the principal with the approval of the superintendent of schools. The principal and coordinator of buildings--each within his respective sphere--are responsible for enforcing this rule.

Thousand Islands. Smoking is not permitted in school buildings at any time and is not permitted on school grounds between 8:00 a.m. and 5:00 p.m. any day school is in session.

First offense: Student is sent to principal, is reprimanded, and receives warning. Letter is sent home to parents.

Second offense: Both parents must meet with the principal during school hours.

Third offense: Student is suspended for three days--type of suspension to be determined by the principal and the student's guidance counselor.

Fourth offense: Student and parents appear before Board of Education for further action.

Watervliet. Smoking by students in the school building or on school grounds is strictly forbidden at all times. This policy is reaffirmed, first, because the school administration is concerned with both the health of the individual student and health problems and annoyance caused the other students by smoking. Second, smoking by students on school property presents a safety hazard.

First violation means "in-school suspension," which requires attending a seminar on smoking and a 1,000-word composition. Parents are notified.

Second violation means two-day suspension from school, follow-up detention and counseling. Parents are notified and there is a mandatory conference. Student and parents are also advised in writing of consequences of a third violation.

For a third violation, following all due process rights, if the student is adjudged to be guilty, he (she) is suspended for the remainder of the semester or a period of 12 weeks, whichever is longer.

peers. Liberty's position is further explained by Superintendent Clarency Parry who says:

"The present curriculum in the schools of New York State and in Liberty Central School advocates teaching about the harmful effects of alcohol, tobacco, and drugs as a major part of the health education instructional program. Therefore, to advocate and support a smoking area would be directly opposed to what we preach."

Erle Smith, superintendent of Erie-Cattaraugus BOCES, corroborates this view.

"It is hardly fitting to designa a smoking area for students in any educational institution when we ar dedicated to teaching the harmful effects of smoking," says Mr. Smith and he adds: "With a concerted poster campaign along with classroom discussions, I believe we have made it fashionable not to smoke--at least at our center."

Another nonsmoking district is Valhalla, whose philosophy is succinctly stated by Superintendent Don J. Marquette. "Our school district has never allowed smoking in school or on school grounds and never will."

Anti-smoking schools do have some problems, but they are small.

George Forbes, chief school officer at Thousand Islands, reports the necessity of policing the lavatories, while in Jamestown a few of the students have complained, "Teachers can smoke; why can't we?" but there has been no pupil swell.

Michael Picciano, principal of Lansing High School, points out that about ten percent of students there smoke. Superintendent George Parry reports that Watervliet's policy, enacted in 1975, gives rule-breakers a chance to mend their ways. It provides penalties for the first two offenses but specifies suspension for the third.

Three other anti-smoking district in the State are Dutchess BOCES, Olean, and Warsaw.

In other New York State districts the situation is different. Official smoking places for high school youth are allowed in Burnt Hills-Ballston Lake, which maintains four adult-supervised outside smoking areas: three in back of the school and one on the side.

"The present plan is the most successful of any we have used," observes Principal William E. Sewell. "It has substantially eliminated smoking and vandalism in the boys' restrooms and has made some improvements in the girls' restrooms."

Auburn and East Aurora provide similar arrangements but restrict usage to lunch periods. Plainedge and Brighton also permit smoking in designated areas before and after school hours.

Albany-Schoharie-Schenectady BOCES has an unusual setup in which each shop has its own boys' and girls' lavatories where smoking is allowed. Rules specify maintained cleanliness, one person at a time, and reasonable use of the facility.

Schools that allow smoking evidently have not granted the privilege lightly. East Aurora permitted the practice only after study and recommendations by a board-staff-student committee, and in Plainedge a seminar on the hazards of smoking is mandatory befor issuance of a pass. Also, parental approval is needed.

A number of districts provide penalties for misuse of the smoking privilege. They range from detention and loss of privilege to clean-up work and suspension.

Reactions of different groups in the schools vary from apathy to dislike. Of the 16 districts reporting to the Journal, most said the faculty showed no interest. One news liaison person summed up teachers' concern as "blah." A minority of the students are interested, with only two to ten percent taking advantage of the smoking privilege. Mixed reactions are shown by custodians; some seem to be glad the mess is confined to one place, while others dislike the chore of cleaning up a smelly area.

D-26

The Right to Write

Some Suggestions on Writing Your Congressman

BY

THE HONORABLE MORRIS K. UDALL
Congressman from Arizona

Surprisingly few people ever write their congressman. Perhaps 90 per cent of our citizens live and die without ever taking pen in hand and expressing a single opinion to the man who represents them in Congress -- a man whose vote may decide what price they will pay for the acts of government, either in dollars or in human lives.

This reluctance to communicate results from the typical and understandable feelings that congressmen have no time or inclination to read their mail, that a letter probably won't be answered or answered satisfactorily, that one letter won't make any difference anyway. Based on my own six years experience, and speaking for myself, I can state flatly that most of these notions are wrong:

> --Let me say that I read every letter written me by a constituent: a staff member may process it initially, but it will be answered and I will insist on reading it and personally signing the reply.
>
> --On several occasions I can testify that a single, thoughtful, factually persuasive letter did change my mind or cause me to initiate a review of a previous judgment. Nearly every day my faith is renewed by one or more informative and helpful letters giving me a better understanding of the thinking of my constituents.

Mail to a modern-day congressman is more important than ever before. In the days of Clay, Calhoun, Webster and Lincoln congressmen lived among their people for perhaps nine months of the year. Through daily contacts in a constituency of less than 50,000 people (I represent 10 times that many) they could feel rather completely informed on their constituents' beliefs and feelings. Today, with the staggering problems of government and increasingly long sessions, I must not only vote on many more issues than early-day congressmen but I rarely get to spend more than 60 days a year in Arizona. Thus my mailbag is my best "hot line" to the people back home.

Some Fundamentals

Here are some suggestions that apply to all congressional mail:

Address it properly: "Hon. _________, House Office Building, Washington, D. C. 20515." Or "Senator ________, Senate Office Building, Washington, D. C. 20510." This may seem fundamental, but I once received a letter addressed like this: "Mr. Morris K. Udall, U. S. Senator, Capitol Building, Phoenix, Arizona. Dear Congressman Rhodes. . ."

Identify the bill or issue. About 20,000 bills are introduced in each Congress; it's important to be specific. If you write about a bill, try to give the bill number or describe it by popular title ("truth in lending," "minimum wage," etc.)

The letter should be timely. Sometimes a bill is out of committee, or has passed the House, before a helpful letter arrives. Inform your congressman while there is still time to take effective action.

Concentrate on your own delegation. The representative of your district and the senators of your state cast your votes in the Congress and want to know your views. However, some writers will undertake to contact all 435 Members of the House and 100 senators, who cast votes for other districts and other states. If you happen to be acquainted personally with a Member from Nebraska, he might answer your letter, but there is a "congressional courtesy" procedure which provides that all letters written by residents of my district to other congressmen will simply be referred to me for reply, and vice versa.

Be reasonably brief. Every working day the mailman leaves some 150 or more pieces of mail at my office. Tomorrow brings another batch. All of this mail must be answered while I am studying legislation, attending committee meetings and participating in debate on the House floor. I recognize that many issues are complex, but your opinions and arguments stand a better chance of being read if they are stated as concisely as the subject matter will permit. It is not necessary that letters be typed -- only that they be legible --, and the form, phraseology and grammar are completely unimportant.

Student letters are welcome. Some of the most interesting letters come from high school and college students. Students may not vote, but many of them can be drafted, they must obey the laws we pass, and their opinions are important to me.

In the course of my years in Congress I have received every kind of mail imaginable -- the tragic, the touching, the rude, the crank; insulting, persuasive, entertaining, and all the rest. I enjoy receiving mail, and I look forward to it every morning; in fact my staff people call me a "mail grabber" because I interfere with the orderly mail-opening procedure they have established. Whatever form your letter takes I will welcome it. But to make it most helpful I would suggest these "do's" and "don'ts".

Do's

Write your own views -- not someone else's. A personal letter is far better than a form letter or signature on a petition. Many people will sign a petition without reading it just to avoid offending the circulator; form letters are readily recognizable -- they usually arrive in batches -- and usually register the sentiments of the person or lobbying group preparing the form. I regret to report that form letters often receive form replies. Anyway, I usually know what the major lobbying groups are saying, but I don't often know of your experiences and observations, or what the proposed bill will do to and for you. And I often am not fully aware of new conditions and developments in Arizona. A sincere, well-thought-out letter from you can help fill this gap.

Give your reasons for taking a stand. Statements like "Vote against H.R. 100; I'm bitterly opposed" don't help me much. But a letter which says "I'm a small hardware dealer, and H.R. 100 will put me out of business for the following reasons..." tells me a lot more. Maybe I didn't know all the effects of the bill, and your letter will help me understand what it means to an important segment of my constituency.

Be constructive. If a bill deals with a problem you admit exists, but you believe the bill is the wrong approach, tell me what the right approach is.

If you have expert knowledge, share it with your congressman. Of all the letters pouring into a congressman's office every morning, perhaps one in a hundred comes from a constituent who is a real expert in that subject. The opinions expressed in the others are important, and will be heeded, but this one is a real gold mine for the conscientious Member. After all, in the next nine or ten months I will have to vote on farm bills, defense bills, transportation bills, space, health, education, housing and veterans' bills, and a host of others. I can't possibly be an expert in all these fields; many of my constituents are experts in some of them. I welcome their advice and counsel.

Say "well done" when it's deserved. Congressmen are human, too, and they appreciate an occasional "well done" from people who believe they have done the right thing. I know I do. But even if you think I went wrong on an issue, I would welcome a letter telling me you disagreed; it may help me on another issue later.

Don'ts

My list of "don'ts" would include these:

Don't make threats or promises. Congressmen usually want to do the popular thing, but this is not their only motivation; nearly all the Members I know want, most of all, to do what is best for the country. Occasionally a letter will conclude by saying, "If you vote for this monstrous bill, I'll do everything in my power to defeat you in the next election." A writer has the privilege of making such assertions, of course, but they rarely intimidate a conscientious Member, and they may generate an adverse reaction. He would rather know why you feel so strongly. The reasons may change his mind; and threat probably won't.

Don't berate your congressman. You can't hope to persuade him of your position by calling him names. If you disagree with him, give reasons for your disagreement. Try to keep the dialogue open.

Don't pretend to wield vast political influence. Write your congressman as an individual -- not as a self-appointed spokesman for your neighborhood, community or industry. Unsupported claims to political influence will only cast doubt upon the views you express.

Don't become a constant "pen pal." In a newsletter appealing for more constituent mail I don't want to discourage letters, but quality, rather than quantity, is what counts. Write again and again if you feel like it, but don't try to instruct your congressman on every issue that comes up. And don't nag at him if his votes do not match your precise thinking every time. Remember, he has to consider all his constituents and all points of view. Also, keep in mind that one of the pet peeves on Capitol Hill is the "pen pal" who weights the mail down every few days with long tomes on every conceivable subject.

Don't demand a commitment before the facts are in. If you have written a personal letter and stated your reasons for a particular stand, you have a right to know my present thinking on the question. But writers who "demand to know how you will vote on H.R. 100" should bear certain legislative realities in mind:

> On major bills there usually are two sides to be considered, and you may have heard only one.
>
> The bill may be 100 pages long with 20 provisions in addition to the one you wrote about, and I may be forced to vote on the bill as a whole, weighing the good with the bad.
>
> It makes little sense to adopt a firm and unyielding position before a single witness has been heard or study made of the bill in question.
>
> A bill rarely becomes law in the same form as introduced. It is possible that the bill you write me about you would oppose when it reached the floor.

The complexities of the legislative process and the way in which bills change their shape in committee is revealed by a little story from my own experience. One time a couple of years ago I introduced a comprehensive bill dealing with a number of matters. I was proud of it, and I had great hopes for solving several perennial problems coming before Congress. However, after major confrontations in committee and numerous amendments I found myself voting against the "Udall Bill."

Conclusion

During the two year life of this Congress, the House clerk will record my votes on more than 250 issues. But in a very real sense these will not be "my" votes; they will be yours too. There are more than 500,000 Americans in the 2nd Congressional District of Arizona, but when the clerk calls the roll, he calls only my name. Thus these 250 votes I cast will speak for you in the decisions our country must make in the next two years.

I need your help in casting those votes. The "ballot box" is not far away. It's painted red, white and blue, and it reads "U.S. Mail."

Morris K. Udall,
Member of Congress,
Second District of Arizona

The NEA Citizenship Committee is grateful to Congressman Udall for permission to reprint his good advice to his constituents, which first appeared in his Congressman's Report, Vol. VI, No.1, January 20, 1967.

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1/70 : 9/71 [illegible]

OPERATIONAL DEFINITIONS

Alternative programs -- programs whereby youths who rather than being processed through the criminal justice system after arrest, are instead diverted into treatment, rehabilitation, counseling, alternative schools, or other such programs in lieu of incarceration, probation, parole, or suspension.

Drug -- any chemical substance which affects a person in such a way as to bring about physiological, emotional, or behavioral change.

Drug Abuse -- drug abuse is the non-medical use of a chemical or substance, licit or illicit, which results in an individual's physical, mental, emotional, or social impairment.

Non-Medical Use of Drugs -- the use of any drug, by any person for purposes other than the prevention, treatment, or cure of an illness or disabling condition.

Seller or Pusher -- sell means to sell, exchange, give or dispose of to another, or to offer or agree to do the same.

1. Means having in his/her possession a quantity of substance beyond what would be reasonable for his/her own use. Possess means to have physical possession of, or to otherwise exercise dominion or control over, tangible property.
2. A student fits into this category if it can be shown beyond reasonable doubt this student has given or sold drugs to other persons.

User --

1. A student who appears to be under the influence of some substance while in the school or on school property, or at a school activity may be a user.
2. A student is discovered to be in possession or in the control of licit or illicit drugs in the course of usual observation or upon appropriate search in such a small amount as to indicate it is for his/her own use.

Due Process -- refers to maintaining a process which is synonomous with "fair play" and does not condone arbitrary actions in the treatment of individuals.

TALKING TO GROWNUPS
ABOUT DRUGS

WORKSHOPS

TALKING TO GROWN-UPS ABOUT DRUGS

Parents today have many questions and concerns regarding drugs and their effects on their children's physical and mental health. The following pages are an attempt to provide parents with some of the answers to these questions. Most children will come in contact with drugs such as marijuana, in one form or another, prior to finishing high school and exposure to socially accepted drugs such as tobacco and alcohol will be impossible for them to avoid.

Suzanne Fornaciari, author of "How to Talk to Kids About Drugs" contends, "The issue of drugs does not have to be a stumbling block for families. If your family can deal openly with the facts of drug use and abuse, the myths that surround drugs, and the feelings associated with them; if you can talk honestly about the problem of growing up with support and understanding, then you can help your children get through the hardest times and give them the personal strength to make choices that keep them healthy and happy."

The purpose of the following section is to provide lesson plans for workshops for parents and teachers that will give them the necessary information to deal effectively with their children regarding tobacco, drugs and alcohol. These lessons were designed mainly for parents/teachers of students who are not deeply involved in the drug scene. Senior high level health education teachers in respective districts can provide the lesson plans used for that level if more sophisticated sessions are desired.

SCOPE OF LESSON PLANS

I. Drugs

  A. Drug Terms
  B. Pharmacological drugs
  C. Toxic Solvents
  D. Narcotics
  E. Mind expanding drugs
  F. Effects on human body
  G. Symptoms related to drug abuse
  H. Drug user's terminology

II. Marijuana

  A. Names for marijuana
  B. Physiological effects of marijuana
  C. Psychological effects of marijuana
  D. Marijuana through the years (What has happened to potency, usage and age of users)
  E. THC
  F. Medical uses for marijuana
  G. Criminal impact of marijuana use and sales
  H. Odor of marijuana

III. Alcohol

  A. What is alcohol
  B. Types of alcohol
  C. Effects of alcohol on the body
  D. Fetal Alcohol Snydrome
  E. Alcohol consumption
  F. Reasons for teenage drinking as compared to adult drinking
  G. Drinking and driving as related to blood alcohol concentration levels
  H. Signs of alcoholism

IV. Tobacco

  A. Chemicals found in a cigarette
  B. Physiological effects of smoking
  C. Diseases related to cigarette smoking
  D. Pro's and Con's for smoking
  E. Cigarette advertising, a case of economics only

V. Review

  A. A complete handout reviewing all areas covered.
  B. Answer key for above.

LESSON PLAN

Unit: Chemical Substances

Lesson Topic: Drugs

Session: 1 (Materials may be expanded or condensed to cover 2-3 sessions)

Time allotment: 2-3 hrs.

Objectives:

1. To define what is meant by the word drug.
2. To recognize the meanings of the following words: tolerance, dosage, physical and psychological addiction, misuse and abuse, overdose and withdrawal.
3. To recognize the various classification of pharmcological drugs. (Depressants, stimulants, narcotics, hallucinogens, deliriants.)
4. To be able to identify some of the effects of toxic solvents that are inhaled.
5. To know the various types of narcotics and how they affect the body.
6. To be able to identify some of the mind expanding drugs and their effects on the body.
7. To know that permanent damage to the human body may result from drug abuse.
8. To identify symptoms related to drug abuse.
9. To recognize some of the terminology used by drug users.

Content:

1. See handout "Drug Terms" (HO-1)
2. Pharmacological drugs: "Drugs" (HO-2)
3. Toxic solvents, narcotics and mind expanding drugs. See "Drugs" (HO-2), "Fact Sheet" (HO-4), "Angle Dust (PCP) Number One Cause of Mental Illness" (HO-5).
4. Film: "Drugs and the Nervous System", BOCES #832-88, 18 minutes. (Shows how the nervous system is affected first by aspirine, and then by other drugs such as depressants, solvents and LSD).
5. Permanent damage to human body: See brochure: "Hazards of Drug Abuse" (HO-5), also (HO-6) "Drug Related Deaths and Emergency Room Visits Reported for 1979".

6. Symptoms related to drugs abuse. See handouts: "Symptoms and Effects of Drug Abuse" (HO-7), "Drugs and Pregnancy" (HO-8), also "Eye-on Crime/Narcotics Identification Chart" (HO-9).
7. Film: "Drugs: The First Decision", BOCES #831-261, 9 minutes.
8. Drug users terminology. See handouts: "A Drug User's Glossary" (HO-10) and "How They Say It" (HO-11).

Learning Activities	Resources
1. Get reaction from parents on what their definition of a drug is. Distribute HO-1 "Drug Terms" - go over all terms on sheet.	1. HO-1 "Drug Terms"
2. Pharmacological drugs: Distribute HO-2. Also see "Fact Sheet" HO-3.	2. HO-2 "Drugs", HO-3 "Fact Sheets - "Heroin and Barbiturates"
3. Using handout "Drugs" (HO-2) review toxic solvents, narcotics and mind expanding drugs. Distribute (HO-4 & 5A "Angel Dust" (PCP) Number One Cause of Mental Illness" and PCP Fact Sheet" film "Drugs and the Nervous System" (Relate what was discussed on handout HO-2 to film. Film displays how certain drugs effect the impulses the brain receives).	3. HO-2 "Drugs", HO-4 "Fact Sheet PCP", HO-5A "Angel Dust Number One Cause of Mental Illness" Film "Drugs and Nervous System" - Cortland-Madison BOCES - #832-88
4. Permanent damage. See HO-5 "Hazards of Drug Abuse" also distribute and go over HO-6 "Drug-Related Deaths and Emergency Room Visits Reported for 1979".	4. HO-5 "Hazards of Drug Abuse" HO-6 "Drug-Related Deaths" and Emergency Room Visits Reported for 1979"
5. "Symptoms and Effects of Drug Abuse" HO-7 go over. Distribute handouts HO-8 & 9, "Drugs and Pregnancy" and "Eye-On-Crime Narcotics Identification Chart". Show film "Drugs: The First Decision". (After film ask: Why do people experiment with drugs? In the film we found that some people use drugs to have experiences that are in contrast to their daily lives. What are some other activities that might provide pleasant contrasts to everyday activities?	5. HO-7 "Symptoms and Effects of Drug Abuse" HO-8 "Drugs and Pregnancy" HO-9 "Eye-On-Crime Narcotics Identification Chart" Film: "Drugs: The First Decision" - Cortland-Madison BOCES #831-201

6. Drug user's terminology. See HO-10 "A Drug User's Glossary" and HO-11 "How They Say It."	6. HO-10 "A Drug User's Glossary" HO-11 "How They Say It"

LESSON PLAN

Unit: Chemical Substances

Lesson Topic: Marijuana

Session: 2 - Materials may be expanded or condensed to cover 1-3 sessions

Time Allotment: 1½ - 3 hours

Objectives:

1. State several common names used for marijuana.
2. Summarize the physiological (bodily) effects of marijuana.
3. Cite the psychological (mental and emotional) effects of marijuana.
4. Identify what has happened to the potency of marijuana, the incidence of usage, and the age of the user over the most recent years.
5. Name the active mind-altering ingredient (psychoactive) in marijuana.
6. Investigate some proposed medical uses for the chemicals in marijuana.
7. Describe the cultural impact of the expanding criminal network of marijuana growers, smugglers, distributors, and paraphernalia pushers.
8. Recognize the odor of burning marijuana.

Content:

1. See Study guide for videotape Reading, Writing, and Reefer", HO-12. See HO-13 for the answers.
2. A continuum to assess present attitudes concerning marijuana given prior to lesson and after lesson, HO-14.
3. True or false quiz given prior to videotape and after to measure change in general knowledge about marijuana, HO-15. See HO-16 for the answers.

Learning Activities	Resources
1. State objectives of lesson	
2. Using continuum on HO-14, ask every member of the group to state which feeling on the continuum best describes his/her present belief about marijuana. Do as a human continuum with masking tape on floor or draw mark responses on chalkboard.	2. HO-14 Continuum statement.

3. Administer true or false quiz HO-15, direct to change as information is acquired from the videotape using questions on study guide.	3. HO-15 "True or False Pretest" Answers HO-16 are not to be given yet.
4. Distribute study guide outline "Reading, Writing and Reefer", HO-12. (Direct participants to fill in questions during videotape.)	4. HO-12-Study Guide "Reading, Writing and Reefer".
5. Show videotape "Reading, Writing and Reefer".	5. Viedotape "Reading, Writing and Reefer" - 1 hr. (52 min.). (Report hosted by Edwin Newman interviews kids 12-16 years old). Cortland BOCES.
6. Using answer key to content outline go over questions.	6. HO-13 answer key.
7. Following viewing, ask again what their views are concerning marijuana, HO-14 Assess change.	7. HO-14 Continuum.
8. Give them answers to self pretest HO-16.	8. HO-16 answers to pretest.
	9. Other Sources: a) Film 16mm "Marijuana" - #833-56, Cortland-Madison BOCES. (Exaggerated portrayals of the effects of marijuana - could be used as a springboard to discussion on scare tactics). b) HO-17 "For Parents Only". What you need to know about marijuana". c) HO-18 "Parents, Peers and Pot". d) HO-19 abd HO-20 "Fact Sheets" and "This Side Up" - obtain from National Institute on Drug Abuse, 5600 Fishers Lane, Rockville, MD 20857. e) "Marijuana, Time for a Closer Look" by Curtis L. Janeczke, Healthstar Publications, (Excellent).

LESSON PLAN

Unit: Chemical Substances

Lesson Topic: Alcohol

Session: 3

Time Allotment: 2-3 hours

Objectives:

1. To define what alcohol is.
2. To distinguish between the different types of alcohol.
3. To identify the effects of alcohol on the body.
4. To describe the symptoms of "Fetal Alcohol Snydrome" (FAS).
5. To recognize that the effects are related to the amount consumed.
6. To state reasons why adults drink as compared to why teenagers drink.
7. To interpret the effects drinking has on driving as related to blood-alcohol concentration levels.
8. To explain the signs of alcoholism.

Content:

1. See content guide "Alcohol Use and Abuse". (HO-21) and fact sheet (HO-22).
2. Use "Alcohol Quiz" as a pre-test and use as a post test upon completion of program. (HO-23).
3. Effects of alcoholism on the body - See brochure "Medical Hazards with Alcoholism" HO-25.
4. Film "Fetal Alcohol Syndrome" - See study guide (HO-26) and HO-27.
5. Effects on body as related to alcohol consumption. See "content guide" HO-21,"Drinking Phases of Alcoholism" handout HO-28 and "A Profile of the Problem Drinker" HO-29.
6. Reasons for drinking - See "content guide" (HO-21). Film: "Alcohol and You" - Explores social pressures and drinking habits that can lead to becoming an alcoholic. (Steps same as those in content guide).
7. Driving and alcohol - See handout " Alcohol and Driving" (HO-30) and "content guide" (HO-21).
8. Signs of alcoholism - See "content guide" HO-21 and handout "Alcoholism Test" (HO-31).

Learning Activities	Resources
1. Distribute "Alcohol Quiz" (HO-23) as a pretest. Go over test at end of program. Instruct participants that they may make any corrections prior to going over it.	1. HO-23 - "Alcohol Quiz".
2. Types of alcohol - Distribute "Alcohol Content Outline" HO-21 review types and uses. Lead into discussion of alcohol as a drug, poison, fuel, medicine, antiseptic. Distribute fact sheet HO-22.	2. HO-22 - "Alcohol Fact Sheet".
3. Effects of alcohol on the body - Turn to Alcohol Content Guide HO-21 page 2, Effects on Body-III. See HO-25 "Medical Hazards with Alcoholism".	3. HO-21 - "Alochol Content Outline". HO-25 - "Medical Hazards with Alcoholism" by W.R. Spence.
4. Distribute HO-26 on fetal alcohol syndrome. Show film: "Fetal Alcohol Syndrome" - 13 minutes. Go over worksheet after film. Also see HO-27 for Synopsis of film.	4. Fetal Alcohol Syndrome Outline, HO-26. Film: "Fetal Alcohol Syndrome" - Cortland-Madison BOCES #832-551. Film Summary sheet (HO-27).
5. Effects of alcohol on body as related to consumption. (Alcohol Outline HO-21 page 3. General effects of alcohol V.) Also distribute HO-28 - "Drinking Phases of Alcoholism". Review.	5. Alcohol Content Outline HO-21, and HO-28 "Drinking Phases of Alcoholism".
6. Show film: "Alcohol and You" - 28 minutes. Relate reasons for drinking to Alcohol Content Outline HO-21, pages 3 and 4. Why do some people drink?	6. Film: "Alcohol and You" Cortland-Madison BOCES #833-55. Alcohol Content Outline-HO-21.
7. Distribute HO-30. "Alcohol and Driving". Review. Also cover Alcohol Content Outline HO-21 page 4, Drinking and driving segment.	7. HO-30 - "Alcohol and Driving" and "Alcohol Content Outline" (HO-21).
8. Sings of alcoholism. Have parents take "Alcoholism Test" (HO-21). Discuss results. Turn to "Alcohol Content Outline", pages 5-7 and discuss alcoholism. Also cover HO-29 - "Profile of the Problem Drinker".	8. HO-31 - Alcoholism Test, HO-21 "Alcohol Content Guide" and HO-29 "Profile of the Problem Drinker".
9. Go over quiz (HO-23) taken at beginning of alcohol study. Read orally each question and discuss.	9. "Alcohol Quiz" - HO-23.

LESSON PLAN

Unit: Chemical Substances

Lesson Topic: Tobacco

Session 4-5: (More than one session maybe needed if biofeedback and blood pressure study is to be done by whole group)

Time Allotment: 2-4 hrs.

Objectives:

1. To cite the various chemicals found in a cigarette.
2. To identify the effects of cigarette smoke on the respiratory system and rest of the body.
3. To recognize that smoking is detrimental to one's health.
4. To conclude that the relationship between cigarettes and advertising is one of economics only.

Content:

1. Chemicals found in cigarette smoke contains over 200 identified poisons. HO-32 - "Chemical Makeup of Tobacco and Tobacco Smoke Chart" also see HO-33, "Tar and Nicotine Content of Cigarettes Chart".
2. Physiological effects of smoking: See guide from American Cancer Society - "Smoking Experiments for School Science Class".

   or

   See biofeedback instructions, HO-35. Biofeedback equipment is available to educators from The American Lung Association and can be used to measure effects of smoking on the body. Blood pressure kits for group use may be obtained from the Cortland-Madison BOCES: See HO-36, "Blood Pressure".
3. Diseases related to cigarette smoking. See HO-37, "Smoking and Your Health". Film: "Breath of Air", #832-361 from Cortland-Madison BOCES, explores the effects of smoking on the human body.
4. Pro's and Con's for smoking Film: "A Decision For Mike", #832-399, Cortland-Madison BOCES. Examines cigarette advertisements: (A case of economics, not health), also review HO-38, "Tobacco Smoke Emissions".

Learning Activities	Resources
1. Distribute copies of HO-32, "Chemical Makeup of Tobacco Smoke". Relate that in concentrated forms these chemicals are deadly poisons! About 200 or more chemicals found in one cigarette. Look at the Tar and Nicotine content chart of various cigarettes, (HO-33).	1. HO-32, "Chemical Makeup of Tobacco and Tobacco Smoke" Chart and HO-33, Federal Trade Commission chart of "Cigarette Tar and Nicotine Content 1979".

2. Physiological effects of smoking may be taught by using either "Smoking Experiments for School Science Classes" guide experiments #1,2,3,4,5,6 and 11. Under student experiments, and experiments #1 & 2 under Teacher Demonstrations or Physiological effects of smoking may be studied by following the Biofeedback Guide. This is a complete study of the immediate effects of smoking on the body. Equipment and help may be obtained from the American Lung Association located in Syracuse, NY. Blood pressure kits may be obtained from the Cortland-Madison BOCES. Also see HO-36 on how to take blood pressure.

2. HO-34, "Smoking Experiments for School Science Classes Guide" - American Cancer Society. HO-35, Biofeedback Equipment-American Lung Association, Syracuse, NY. Also HO-36, "Blood Pressure Guide" (Blood pressure kits, Cortland-Madison BOCES).

3. Diseases related to cigarette smoking. Using HO-37, "Smoking and Your Health", list diseases related to cigarette smoking on blackboard. Reinforce by viewing film "Breath of Air", 21 minutes.

3. HO-37, "Smoking and Your Health". Film: "Breath of Air" Cortland-Madison BOCES #832-361.

4. Pro's and Con's of smoking. Film "A Decision For Mike", 19 minutes.

Pro's

Release of tension
Enjoyment
Status
Relaxation
Sophistication
Loose weight

Con's

Cancer
Bad breath
Yellow teeth
Social crutch
Emphysema
Cough
Sense of taste impaired
Sense of smell dulled

All of the other diseases realted to smoking and physiological effects.

4. Film: "A Decision For Mike", Cortland-Madison BOCES, #832-399, Local American Cancer Society Unit. Clippings of cigarette advertisements.

- After viewing film have parents list pro's and con's for smoking.

4. Hold up pictures of cigarette advertisements discuss how they try to hide the true effects of smoking. Point out the relationship of cigarettes and advertising is one of economics only. Also HO-38, "Tobacco Smoke Emissions".

4. HO-38 "Tobacco Smoke Emissions".

LESSON PLAN

Unit: Chemical Substances

Lesson Topic: General Review

Session 6

Time Allotment: 1-2 hrs.

Objectives:

1. To reinforce concepts covered in chemical substances unit.

Content: See handout "Tobacco, Drugs and Alcohol Review".

Learning Activities	Resources
Pass out "Tobacco, Drugs and Alcohol Review" HO-38. With whole group participating go over each question.	
Other fun ways of reviewing	
1. Using Coleco Quiz Wiz game and Quiz Book #1 (comes with machine, one should be sure that they get the machine Quiz Book #1 because this corresponds to questions on Tobacco, Drugs and Alcohol Review handout), divide class in half. It adds interest if each team selects a name for itself using terminology from this course. Then select one person to be the game key punch operator. A question is read to a parent, on one of the teams. S/he then gives the answer to the key punch operator who, in turn, punches the answer into the machine. If the green light goes on indicating that the answer is correct, that team then receives one point. If the red light goes on indicating that the answer is incorrect, then the opposing team must then try to answer the question. A running tally of correct answers for each team is kept. The team with the most points is the winner.	HO-39, "Tobacco, Drugs and Alcohol Review". (Instructor may want to make a transparency from this and use on an overhead projector). Coleco Quiz Wiz game and Quiz booklet #1 costs about $20 and can be found in most department stores. HO-40 - "Quiz Wiz Answer Key" Answers to "Tobacco, Drugs, and Alcohol Review".

2. This review can also be done with a person acting as a master-of-ceremonies asking members in each group questions from the "review handout". One point can be given for each correct answer. The team with the most points is the winner.

DRUG TERMS

1. Drug: Any chemical substance that alters mood, perception or consciousness and that can be misused to the apparent injury of self or society. (Simply, any chemical that affects the normal functioning of body).

2. Tolerance A state in which the body's tissue cells adjust to the presence of a drug. However, the body must readjust virtually all of its normal functions to compensate for the presence of the drug. As the body's tolerance grows, increased quantities of the drug are required to produce the desired effect. (The drug user needs more of the drug in order to experience the same effect as before).

3. Dosage: The amount of the drug taken.

4. Physical addiction (dependence): The state which occurs when a person cannot function normally without the repeated use of a drug. If the drug is withdrawn, the person has severe physical and psychic disturbances. (In this state a person will do anything to get the drug. If he can't get it, he becomes physically ill).

5. Psychological addiction (psychological dependence or habituation): The result of repeated consumption of a drug or narcotic which produces psychological, but no physical reliance on it. The psychological dependence produces a desire (not a compulsion) to continue taking the drug(s) for the sense of improved well-being.

6. Drug misuse: The use of drugs for purposes or conditions for which they are unsuited or for appropriate purposes, but in improper dosage.

7. Drug abuse: The excessive or persistent use of a drug without regard to accepted medical practice. (The use of drugs for reasons other than what they were intended).

8. Withdrawal: Condition which occurs when an individual who is physically dependent on a drug stops taking that drug. Symptoms vary with the drug and may include nausea, dizziness, chills, runny nose and itching.

9. Overdose (O.D.): Taking so much of a drug that it becomes potentially lethal.

HO-2

DRUGS

I. Depressants - (sedatives - slow down the nervous system)

- A. Uses
  - 1. Relieve pain
  - 2. Decrease emotional anxiety - calming effect
  - 3. Users are called "pill heads"
- B. Take their names from thier colors: Red Devils,Red Birds, Yellow Jackets, Blue Angels, Pink Ladies. Christmas Trees, Green Dragons, Rainbows, Blue Heavens.
- C. Some common depressants - alcohol, aspirin, chloral hydrate (knock-out drops)
- D. Barbiturates - Downers, goofballs, barbs, candy
  - 1. Doctors use to treat insomnia, epilepsy, nervous and mental disorders.
    - a. promote sleep
    - b. tranquilize
    - c. allay anxieties and fears
    - d. Their use has revolutionized the treatment of the mentally ill and helped normal people face crises.
  - 2. Synthetic drugs made from coal tar - white powder in colored tablet or capsule form.
  - 3. Over 3,000 deaths per year are blamed on the overuse of barbiturates alone. They account for approximately 25% of all acute poisoning cases admitted to hospitals.
  - 4. Examples: Barbital, secobarbital, amobarbital, phenobarbital, pentobarbital, and pentothal, sodium pentothal (truth serum).
  - 5. The barbituate habit is closely related to personality problems - the upset, neurotic person often takes them to escape from worry and for rest.
  - 6. It is impossible to predict the effect they will have on a person.
  - 7. Large doses produce incoordination, mental confusion and emotional instability, impaired judgment, slowed reaction time, and lowered intellectual functioning.
  - 8. The greatest danger is the combination of barbiturates with alcohol. Since both are central nervous system depressants, together they produce over twice as powerful an effect(potentiation). Death may result.

II. Stimulants - (Excite the nervous system)

- A. Uses
  - 1. Prevent sleep.
  - 2. Stimulate emotional excitement.
  - 3. Supress appetite.
- B. Typical names - co-pilots, wake-ups, whites, brownies, crossroads, hearts, cartwheels. (These names apply to amphetamines).
- C. Some common stimulants include cocaine (also a pain killer), and caffeine which is found in tea, coffee, cocoa, (chocolate), cola drinks. Coffee has between 1.5 and 2.5 grains per cup. Tea has slightly less than coffee and cola drinks have about 1/2 that of coffee.

D. Amphetamines - Uppers - pep pills
  1. Cause excitement and sleeplessness (including drugs such as benzedrine, methedrine and dexedrine)
  2. Mind drugs that result in psychic energy (valuable drug for depressed mental patients)
  3. Used in the treatment of depression and weight control (curbs appetite)
  4. Speed Freaks - users of methedrine who show excited and restless behavior.
  5. Amphetamines impair rather than improve physical ability and mental judgment.
  6. Benzedrine
    a. Synthetic compound sometimes used to relieve colds (on the order of NO-DOZ).
    b. Discovered in 1927 - shrinks the mucus membranes as in colds, allergies and hay fever).
    c. Now called "Bennies" or pep pills - cause excitement and sleeplessness.
    d. Truck drivers, night workers, students during exams tend to be the ones who take them to keep them awake.
    e. May impair judgment and vision and produce hallucinations.

E. Speedball - taking depressant and stimulant simultaneously - gives more (exaggerated high).

III. Toxic solvents that are sniffed

A. Some common solvents are gasoline, ether, cleaning compounds, lighter fluid, plastic cements and glue. They contain solvents such as benzene, toluene, carbon tetrachloride, ethyl alcohol and ethyl acetate.
B. Effects:
  1. Pleasant person becomes irritable, violent, has memory losses, lapses of conscioueness (similar to intoxication).
  2. Can cause brain, liver and kidney damage and prevent the manufacture of new blood cells.
  3. Causes inflammation of the nose, eyes, and lung tissues.
  4. The person may feel sick, lose his appetite, and exhibit personality change.
  5. The "gluey" saturates a handkerchief and/or other fabric and inhales the fumes sometimes also making use of paper or plastic bags.
  6. Gluey experiences tingling sensation and feeling of excitement which leads to dizziness, intoxication, and "flash-outs" (losses of consciousness), slurred speech, and staggering. He often does not know where he is or what he is doing.

IV. Narcotics

A. Characteristics:

  1. Generally produce stupor and/or sleep.
  2. No curative value.
  3. Relieve pain.

B. Uses:

  1. Dull the senses and pain during and after surgery or with diseases or injuries.
  2. Promote sleep and calm the emotionally upset.
  3. Relieve discomfort of certain coughs.

C. Cause emotional and physical addiction.
D. Body develops a tolerance for it - needs increased amounts for the same effects.
E. Person gets a withdrawal reaction when the drug is discontinued.
F. Opiates

  1. Opium

    a. Made from the dried juice of the unripe seedpods of the Oriental Poppy.
    b. Faint odor and bitter tasts. (Dark brown or black tarry gum is obtained from the congealed milky juice of the unripe seedpod - crude form.)
    c. Grows in hot climate where there is little rain - Far East, China, Thailand, Burma, Mexico, India, Turkey, Laos, Iran, Russia, and Yugoslavia.
    d. Eaten or smoked in a pipe - produces a dreamy stupor or sleep or unconsciousness.
    e. Sold in small boxes called "toys".
    f. Dilaudid and Metapon - synthetic narcotics (white powder derived from opium).

  2. Morphine

    a. Characteristics:

      1. Used medically to relieve severe pain.
      2. Should never be taken except on a doctor's order.
      3. Continued use of morphine can result in addiction.
      4. Made from opium, but 10 times stronger.
      5. Tolerance can be developed with continued use.
      6. Sold to the addict diluted with quinine or milk sugar.
      7. Small doses relieve pain and heavier doses produce sleep.
      8. Fine, white, feathery powder.
      9. Odorless and bitter taste.

    b. Isolated in 1805 by Frederick W.A. Serturner, chemist, who named it Morpheus for the god of sleep.
    c. Injected in soltuion form under the skin or into a vein.
    d. Addicts get it in powder or capsule form called "caps" and in folded packets called "decks".
    e. Dealers and users refer to it as "M" or some word beginning with "M" like monkey. Sometimes called M.S. for Morphine Sulphate.
    f. Dealer mixes it with cheap white powder such as talc or milk sugar that looks like morphine itself. By diluting the pure drug, he makes a greater profit.
    g. Withdrawal symtoms include a total state of misery: emotional and physical irritability; nervousness, headache, twitching, tremor, and vomiting. Occasionally withdrawal may be fatal.

3. Heroin

    a. Made from opium.
    b. Twice as strong as morphine and 20 times as strong as opium.
    c. White, crystalline powder that has to be cooked into solution before injection. Bootleg heroin is brown and impure.
    d. So dangerous that its manufacture even for medicinal purposes has been outlawed.
    e. Made mostly in Italy, Turkey, France and Germany.
    f. Sold in same forms as morphine - mostly caps.
    g. Starts with sniffing: goes on to needling; and on to mainlining.
    h. Called "H" or Horse or Harry - some word beginning with "H".
    i. 98% of the narcotic addicts use this drug.

4. Codeine

    a. Made from morphine.
    b. 1/6 as strong as morphine and, therefore, less addicting.
    c. White powder or crystals.
    d. Found in some cough syrups - depresses cough reflex and promotes sleep.
    e. Percodan - derivative of codeine, but stronger, relieves pain.

5. Morphine substitutes - synthetic

    a. Demerol
    b. Methadone - often used in withdrawal of addicts.
    c. These drugs have the same narcotic effects.

G. Cocaine

1. White odorless powder with a bitter taste.
2. Made from the leaves of the coca plant in East Indies, Java, Brazil, Peru, and other South American countries.
3. Called "C", coke, or snow - user is called a "snowbird".
4. Sold in capsules or folded papers or in cubes. For doctor's use it comes in powder form or tablets.
5. Locally (externally) deadens nerves in area to numb mucus membranes or skin - local anesthetic without loss of consciousness.
6. Large doses internally - acts as a stimulant on nervous system producing irritability, loss of appetite, and sleeplessness. Often temporary euphoria followed by great fear and belief that imaginary people are about to harm him. May cause addict to become violent and attack without reason. Therefore, federal government classes it as a narcotic although it does not cause physical dependence or withdrawal.

7. Sniffed up the nose or taken intravenously.
8. Novocaine
    a. Synthetic - Procaine
    b. Milder than cocaine.
    c. Used mostly in dentistry, but also used for spinal anethesia, etc.

V. Marijuana

A. Spanish version of the Portuguese word "mariguano" which means intoxicated.
B. Called by various names: grass, muggles, marywarners, pot, tea, T, hay, reefers, maryjane, hemp,hashish, weed, stick, etc.
C. Resinous powder from the flowers and leaves of the Indian hemp plant. (Hemp seed is often an ingredient in birdseed mixtures).
D. Grown in the southwestern U.S., but can be grown just about anywhere.
E. Smoked in cigarettes which look homemade - sometimes brown paper.
F. Smells like burning weeds of an incense type.
G. Acts on the brain, distorting the person's judgments and sense of time. Seems to make time go by very slowly and cause a loss of the sense of reality. Person may commit violent acts, but more often becomes lethargic. Produces intoxication.
H. Some believe it is a sedative drug, but the person feels he is stimulated.
I. A well-adjusted person may get no pleasure from it, but the maladjusted, unhappy person often does.
I. THC - tetrachydrocannabinol
    1. Synthetic marijuana or the active component of the natural compound.
        a. Marijuana may have adverse psychological effects on adolescents who may fail to learn to cope with life if they become potheads, and it is certainly dangerous to drivers. In addition, new research hints that marijuana may have serious physiological effects that should make it, like cigarettes, carry a warning: "Caution: marijuana may be hazardous to your health". Investigators are studying the basic pharmacology and toxicology of the agent, its metabolism in the body and its possible cancer-causing and birth defect effects, as well as its potential as a therapuetic drug.
    2. THC inhibits microsomal (liver) enzymes that play a role in the metabolism of drugs which could lead to potentially lethal situations. For example, if a marijuana user also took barbituates, he might be unable to metabolize those drugs and an accumulation in the blood could be fatal.
    3. THC exhibits a mix of both stimulatory and depressant activity on the central nervous system unlike any other class of compounds.
    4. The possibility that marijuana is teratogenic, causing damage to unborn children, is a specter that as yet cannot be put down. THC readily crosses the placenta and enters the fetus.

Psychedelics or Hallucinogens

A. Mind-expanding drugs.
B. Examples:
    1. Psilocybin - A Mexican mushroom derviative
    2. Ibograine - extract from an African plant
    3. Mescaline - an alkaloid: active ingredient of the mescal cactus. Produces loss of inhibitions and the person begins describing past episodes of his life (concentrated form of Peyote).
    4. Peyote - dried button of peyote, a cactus, that grows on the deserts of the southwestern U.S.
    5. DMT - Dimethyltryptamine - synthetic form of Mescaline
    6. LSD - Lysergic Acid Diethylamide - a derivative of an alkaloid in ergot, a fungus that grows on wet grass and grain.
C. LSD 25
    1. Tasteless, odorless, colorless (virtually invisible)
    2. Discovery: Dr. Albert Hofmann, chemist with Sandoz Laboratories in Basel, Switzerland, is the first to have experienced the powers of LSD in hope of developing a useful stimulant for the central nervous system. (Sandoz Pharamaceuticals of Hanover, N.J. was the only legitimate distributor of the drug, but withdrew and recalled it when it became abused.
    3. Can be made in a chemistry lab or can be bought by bootleggers.
    4. Dr. Hofmann accidently ingested a speck and was overcome by a kaleidoscope of shapes and colors that flashed through his mind and he had to go home to bed. As a dedicated researcher, he swallowed another tiny dose in an effort to pinpoint the cause of his weird experience. When he got the effects again, he feared he was going "crazy" and saw his body lying dead on a sofa while his "alter ego" moved about the room moaning.
    5. Dosage:
        a. 1/300,000 of an ounce - approximately the size of a floating dust particle.
        b. 100 micrograms: effects in 30-45 minutes and lasting 10-14 hours, may last up to three days.
        c. Does not cause lethal poisoning itself, but can give an overpowering feeling of omnipotence.
    6. No one except qualified researchers should use or touch the stuff. It is not worth the risk. At least 1/3 report unpleasant emotions and sensations. About 1/2 experience panic and fear they are losing their minds.
    7. Effects:
        a. "Trip" - onset about 1/2 hour - lasting several hours.
        b. Turn themselves on by chewing an inexpensive sugar cube impregnated with a speck of LSD.
        c. Sometimes the pushers coat the glue on envelope or stamps so that the drug can just be licked off.
        d. It is not physically addicting, but the users are involuntarily propelled into delusions sometimes weeks or months after taking the trip (recurrence - without ever taking the drug again).
        e. Cost varies with availabilty.

f. Scientists are unable to trace exactly what happens to it in the body.

g. Some trips are contemplative affairs and others find "trippers" taking off their clothes and turning on orgiastically.

h. The users say the drug presents a new world of flashing lights, colorful patterns, memories out of the past, sharpened insights into humanity, etc.

i. There is an aura of sexuality about LSD. Though, contrary to popular belief, it does not increase sexual desire or prolong the act of intercourse, it has been found to dull sexual capacities. However, it tends to make the person feel that he loves everyone and the world is a great place and, if anyone wants to go to bed with this person, it's just one more great experience. Pregnancy may become serious side effect.

8. The drug is called "acid" and its users "acid heads".

9. The drug has been tried in the treatment of schizophrenics and alcoholics, but so far has not proven too successful.

10. Under the influence of LSD, a youth on a California airplane, attacked a stewardess in an effort to force his way into the pilot's cabih. Later, he explained to police that he wished to get a better view of the pretty rainbows.

11. A Los Angeles student stepped in front of a speeding car on Wilshire Boulevard, raised his hands in an effort to "will" the speeding car to stop or come to an instantaneous halt. Obviously, he died as an "indirect casualty" of LSD.

12. Several university students were arrested when neighbors phoned the police because they were observed crawling around on the lawns, eating the grass. Neighbors called police to complain of the noise in a nearby apartment. Police found two young men hacking at one another with knives in order to get blood "to draw beautiful pictures on the wall."

13. Typical trance:
The person's inhibitions melt away and he loses interest in "ordinary" human impulses. He may spend hours in rapturous comtemplation of the "inexpressible beauty in some speck of dirt on the floor or in the geometric fascination of a fingernail." The body may seem split into two or more parts and the person finds it impossible to keep track of where she/he really is or even to tell where she/he leaves off and inanimate objects begin.
The person often gets a powerful urge to jump out of a window or the impression that she/he is a snowflake or a bird. For example: A teenage New York girl cautiously took only 1/2 an LSD sugar cube at the urging of friends. She went home to bed and, unable to sleep when a picture on the wall began to move around, she searched the house for a knife to cut away an unbearable pain in her chest. Her mother called the police who came in the door just in time to catch the girl in mid-air since she had decided to fly downstairs and had leaped from the top of the stairway.

14. Users:
  - a. From the types of people who have become the greatest advocates of LSD, it can be seen that the acid world often reflects an aura of pseudo-intellectuality and adventure.
  - b. Most people concerned with the use of LSD feel that it is about as safe as a do-it-yourself brain surgery kit, but unknowing or uncaring people continue to exploit the drug.
  - c. Most users are white, while 2/3's of New York's heroin addicts are blacks and Puerto Ricans.
  - d. Heroin addiction goes with a sense of social, economic, or personal inferiority since this person seeks euphoria as an escape from the squalor of circumstances and sense of inadequacy.
  - e. LSD users may live in high rises and split levels rather than slum tenements. They are often doctors, lawyers, psychiatrists, and college students. It is found on college campuses, in Greenwich Village, Los Angeles' Sunset Boulevard, San Francisco's Haight-Ashbury District, and, yes, even on Main Street, Cortland.
  - f. Dr. Timothy Leary, a 45 year-old ex-Harvard psychologist and exponent of LSD, was dismissed in 1963 along with his co-worker, Richard Alpert, for giving drugs to students. He called LSD a "cerebral vitamin" when in actuality LSD has no similarity to vitamins in any way. He has been arrested several times on marijuana charges.
  - g. Tranquilizers such as Chlorpromazine afford some relief from the effects. Most LSD takers come through their trips, but of the first 100 tested at Bellevue, 8 did not. They lapsed into real psychosis, usually catatonic or paranoid schizophrenia. Even carefully selected test subjects may become tragedies.
  - h. Examples of LSD experiences:
    - a. A 5 year old-Brooklyn girl, Donna Wingenroth, accidentally swallowed an LSD sugar cube her 18 year-old uncle had bought in Greenwich Village for $5. She became hysterical and had to be hospitalized for five days.
    - b. An ex-medical student was charged with brutally slicing up his mother-in-law in Brooklyn while under the effects of LSD.
    - c. A 29 year-old Yale graduate lying on the ground said that he could look up at the sky and see through the leaves of a plant and see the plant fluids flowing around inside it. "For a while, I became a plant and felt my spine grow down through the bricks and take root..and I raised my arms up and waved them around with the plant and I really was a plant. But toward the end, I was watching Lois (wife) and I thought I saw the drug take hold of her in a bad way. Suddenly I was afraid. I looked down and Lois was miles and miles beneath me sort of as if I were looking at her from the wrong end of a telescope."

d. The business colleagues of a 42 year old woman, without her knowing, slipped LSD into a beverage she was drinking. Soon she had hallucinations and profound suicidal depression which struck her for no apparent reason and she killed herself. Such criminally thoughtless pranks cause people to be convinced that they've gone insane and as a result of their hallucinations, they do.

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SNIFFING FACTS

(Aerosols, Spray Paint, Glue, etc.)

SNIFFING OF VAPOROUS HYDROCARBONS

(This includes toluene, spray paint, aerosols, hair spray, other paints and lacquers, glue, rubber cement, gasoline, kerosene, etc.)

WHY DO PEOPLE USE THESE SUBSTANCES? Many people who wish to get high, for any number of reasons, sniff one or more of these chemicals. Often users are unable to obtain other drugs, or are too young to obtain alcohol in the stores. Toluene, spray paint, and others mentioned are usually found around the house, or can be bought cheaply.

HOW ARE THEY USED? Usually, these substances are applied to a rag and sniffed — or sprayed into some sort of container, and the vapors inhaled. But a person never sprays paint directly on himself, for example.

WHAT KIND OF HIGH IS IT? It is not a high that lasts for a long time, usually less than 20 minutes, although it comes on fast. The initial "rush" can even be so strong that some users momentarily black out. The feeling is much like being drunk in some ways — there is slurred speech that makes the user hard to understand, and confusion in thinking. There is depression of the central nervous system, which also happens with other drugs such as alcohol, herion and barbiturates (sleeping pills).

WHO USES THEM? Sniffing of most of these substances is usually done by young people, most of them aged 10 to 14. However, sometimes it is also done by those who are much younger, or older. A lot seems to depend on money; lower income families have more children who experience sniffing of these chemicals at least once. It is done by whites, Blacks, Puerto Ricans and Native Americans. However, more boys than girls do it. The effects are the same on the body no matter who does it.

WHAT ARE THE MOST COMMON SNIFFING PROBLEMS? In the past, many people believed that all sorts of instant harm was done by sniffing. Older information sometimes stated that brain damage, leukemia, liver damage, lung damage, and destruction of bone marrow that produces red blood cells, all took place when people sniffed these chemicals. Now we know that much of this was not true.

There are many other dangers, however, that are very real. Probably the biggest one is called the S.S.D. (Sudden Sniffing Death) Syndrome. This is a complex problem that results in users suddenly falling over dead. For years scientists and doctors wondered why this happened to certain people while they were sniffing vaporous substances.

Toluene, spray paint, glue and other chemicals mentioned all apparently affect the heart in the same way: They make it sensitive to adrenaline, which is the substance released by the body in times of stress. To put it simply, if a person were getting high in a secret place, for example, and all of a sudden was "discovered" sniffing one of these chemicals, he might become frightened, and start to run. This would pump large amounts of adrenaline into the system, which would cause the heart to stop beating, and he would fall over dead. This does not always happen, but it could happen — and it has happened to many people in the past.

Certain other drugs can cause adrenaline to be present in the body as well – such as amphetamines (speed, white crosses, etc.) A person who has recently taken a strong stimulant will also react very badly to the sniffing drugs in many instances.

Some deaths from sniffing have also happened because users sprayed or placed spray paint, glue or other sticky substances into a plastic bag for inhaling. In this case they placed their faces against the bag, experienced an especially big "rush", passed out into the bag, and suffocated.

Other dangers also exist, but they vary according to exactly what is used, and its chemical composition. A chemical called "N-Hexane", which is found in model airplane cement as a solvent (as well as certain other products) apparently can cause permanent, organic brain damage and deterioration. However, other chemicals mentioned may do nc long-term damage, although they all present the immediate dangers listed above.

Gasoline and paint containing lead can cause lead poisoning, since the lead comes into the lungs along with other fumes. Sniffing any kind of spray lubricant, or coating for household cooking (a spray called "Pam" is one example) can coat the lungs and cause immediate suffocation. Many people have died this way.

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State of New York
COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION
Office of Alcoholism and Substance Abuse

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Alcohol and Substance Abuse Fact Sheet Series

HEROIN: SOME BASIC FACTS

WHAT IS IT? Heroin is a drug in the opiate family. It starts out as a milky liquid drained from the pod of the unripe opium poppy. From there it is processed into opium, a solid brownish substance. Opium is refined to produce morphine and codeine, the two more potent of its four alkaloids. Heroin is made by treating morphine with acetic acid, a catalyst which makes the drug many times stronger.

WHERE DOES IT COME FROM? Opium comes from many areas of the world. It can be grown in such places as Southeast Asia, Mexico, Africa, South America and elsewhere — wherever the climate is suitable and the government controls are either lax or for some reason unenforceable. Some of the heroin in the United States comes from Mexico, but most of it originates in various parts of Asia.

Usually, refining opium into heroin takes place somewhere along the smuggling route, in illicit laboratories, before it reaches this country. Smuggling activities take place by land and by sea, on both East and West coasts, and often through Mexico, which is a route for other drugs as well. Today there is no one route or main supplier of heroin into the United States, as there was during the past during the days of the famous "French Connection," when much heroin was shipped from Marseilles, France, to New York City.

WHAT KIND OF HIGH IS IT? Generally, it is a euphoric type of high, characterized by "nodding out" at first, a state that can be described as half asleep and half awake. Bodily, heroin affects the central nervous system (C.N.S.). The pupils of the eyes become tiny. Aches and pains disappear. One of the problems with heroin is that the high is too good: As Dr. David Smith of the Haight-Ashbury Free Medical Clinic once wrote, "It's so good you don't want to try it even once." The main problem is that, as a person becomes addicted to this drug, the high all but goes away. Heroin becomes a means of escaping the pain of withdrawal which comes without regular use. The "high" at this stage, if any still exists, is the last consideration because the drug becomes as important as life itself to the addict.

HOW IS IT USED? Addicts use heroin almost exclusively through injection, with a needle, into the vein. Occasional users may also snort (sniff) the drug, or skin pop — which is injection just under the skin with a needle. For any form of injection, it is necessary to mix the powder with water, heat to dissolve, and strain through cotton. A wide variety of problems occur because the needles — used over and over and sometimes passed from one user to the next — are not sterile and accumulate bacteria which may be harmful. Infections and abscesses, collapsed veins and other painful side-effects may develop.

HOW MANY PEOPLE USE IT? Exact figures are only guesses at best, and depend largely on how much heroin is available on the streets. National estimates range from 750,000 addicts when heroin is plentiful, to 400,000 when it is not. Occasional, non-addicted users may number many times this amount, however. It is possible that at least several million people in the U.S. have tried heroin at one time or another. New York City has the largest number of addicts, but by latest federal figures ranks in 8th place in terms of the ratio of addicts to total population.

IS HEROIN PHYSICALLY DEBILITATING? By all indications, heroin itself does not cause extensive physical damage on the long term (except for ever-present dangers like overdose, etc.). However, the lifestyle of addiction is harmful. The constant cycle of addiction-withdrawal-addiction-withdrawal, coupled with a lack of attention to food and nutrition, causes addicts to age quickly.

WHAT DOES IT LOOK LIKE? Heroin is a white powder in its pure form. However, heroin sold by street dealers is usually very weak, and usually ranges from 1% to 5% purity, with weaker doses being the more common. Since it is not a legally prescribed drug, there can be no sure controls of its purity. Occasionally batches of very strong heroin will accidentally be sold, with the result being more overdoses and near-overdoses than usual. Whenever heroin is cut this way, some sort of white powder must be used for filler. The most common filler is milk sugar, but sometimes quinine is also used, as well as other white powders. Mexican heroin (as well as certain other types) often has a brownish color. In other countries such as Great Britain, heroin may also be pinkish.

IS IT ADDICTING? Yes. When most people think of an addicting drug, they think of heroin. Other addicting drugs include alcohol, barbiturates and some other types of sedatives. To be physically addictive, any drug must produce tolerance and withdrawal. Tolerance means that more and more of the drug must be used eventually to achieve the same level of high. Withdrawal means that when the drug is abruptly taken away, certain symptoms occur -- such as flu-like aches, pains, and runny nose, nausea, vomiting, muscular cramps, and occasional seizures which may be petit mal (small) or grand mal (large). The large seizures happen usually with very heavy addictions, and may sometimes result in death unless medical attention is received, or medication is prescribed beforehand to prevent them.

We do not know everything about the reasons heroin is addicting. One reason may very well be that the human body has the capacity to manufacture its own type of heroin-like pain killer in times of injury or extreme stress. This would explain why the body becomes so easily accustomed to heroin once use of this drug has begun regularly.

WHY DO PEOPLE USE IT? Many people use heroin for many reasons. In some other countries, heroin is legally available on prescription as a pain-killer, for use with such people as terminal cancer patients, where the possibility of addiction may seem unimportant. In this country, however, morphine is more commonly used to kill intense pain.

There are many types of users and addicts. For some people, heroin is used only occasionally as a "social" drug. It is true that this is a very addictive drug, but this does not mean that occasional use will inevitably result in addiction. This depends on the type of person. According to a 1975 study funded by the National Institute on Drug Abuse, the majority of people who try heroin, or use it only occasionally, do not become addicted to it. But this does not mean that heroin is by any means a "safe" drug. The unpredictability of the dosage level alone makes overdose all too easy, and an O.D. is even more common for people who have not had a great deal of experience with this drug. Also, overdoses can happen due to use of heroin and other central nervous system depressants such as alcohol and downs at the same time.

To be an addict, a person must do more than just try heroin once. Some other factor must drive the user to want to experience the feeling over and over again until the drug has a chance to make its addictive potential felt. Few people know if they are the type to become addicted until after this happens. (People never plan to become alcoholics, either, for example.) Once addiction has begun it is very hard to stop, and slowly more and more of the addict's life is taken over by the constant process of always having to afford and find the drug. Addiction is caused by many personal factors, including psychological makeup, individual biochemistry, outside pressures, social acceptance, a need to escape hardships or simple boredom and so on. It is a different pattern for every person. There is no one cause.

WHAT ARE THE MAIN DANGERS? The main dangers are addiction, accidental overdose and other unexplained causes of death. An overdose may, of course, be caused by high strength. But it may also be the result of another mysterious process referred to as "Syndrome X." A real overdose may take up to an hour to be fatal, but in certain cases addicts and occasional users have been found dead very soon after the drug is taken — sometimes with the needle still in the arm. In these cases, analysis of the heroin indicated no unusual strength, or poisonous impurity which might have lead to death. We still do not know the reasons for "Syndrome X," but apparently at some point, for some people, a trigger reaction must take place in the brain which simply tells the central nervous system to give up, and they die. In any case, if death is not immediate, the person can almost always be saved by an injection of NARCAN, which counteracts the heroin in the bloodstream immediately. This is such an effective drug that an overdose victim who is turning blue may wake up a few minutes later wondering what he is doing sitting in a hospital emergency room or drug crisis center.

WHAT KIND OF TREATMENT IS AVAILABLE? Currently, there are many types of treatment for heroin addiction. These include methadone maintenance, in which a legally prescribed — but addicting -- drug is substituted for heroin in a controlled dosage level, which will allow the addict to maintain a steady job and be a socially acceptable member of the community again. The ideal treatments — and the hardest — are those which make the addict drug-free. After an addict is withdrawn from the drug (detoxified), he or she may enter a therapeutic community, away from everyday contacts and friends, to learn how to live in a drug-free state and develop survival skills for when he or she is released back into the world. Other types of programs exist, including counseling centers and work-training programs for recovering addicts. Still other programs are religiously oriented, and rely on spiritually rebuilding the addict. Different programs work for different types of people, and since there is no one type of addict there must be many different approaches to treatment and rehabilitation. Information about local treatment agencies is usually available by looking in the yellow pages of the phone book, in larger cities, or by contacting local counseling or crisis centers, if these exist. Or, information about treatment centers may be obtained by writing the State of New York, Division of Substance Abuse Services, P.O. Box 8200, Albany NY 12203.

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State of New York
COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION
Office of Alcoholism and Substance Abuse

Alcohol and Substance Abuse Fact Sheet Series

FACT SHEET ON BARBITURATES

Barbiturates are a family of drugs which include, among others, secobarbital, amobarbital, phenobarbital and pentobarbital. These are manufactured as medicines under the above "generic" names, or under various "trade" names, such as Seconal, Tuinal, Amytal, Nembutal, and so on.

They are also made illegally in unlicensed laboratories, or the drug in capsule or powder form may be stolen from drug companies or pharmacies. Illicitly obtained powder may be placed in capsules, or compressed into a tablet, which is sometimes candy-coated to make it hold together. These illicit types of barbiturates are usually not pure, and are cut with inert powders, talc, or other weaker drugs.

WHY DO PEOPLE USE BARBITURATES? Many people want to get high for any number of reasons, ranging from escape to curiosity. They may use these drugs, and other "downer" drugs, because they help them "fall out" of the conscious world, and make everything fuzzy. Some people use barbiturates because everyone else is taking them at a party. They may not like school, and these drugs make them less aware of what is happening. Or they may use them to help solve other problems, as medication. When prescribed by a doctor, barbiturates are most often used as sleeping pills.

HOW ARE THEY USED? Barbiturates are most often taken orally, but some users try to inject them with a needle. This is not a good idea because many problems can result, such as abscesses and collapsed veins. Many manufacturers make the powders of these drugs so they cannot be mixed with water, which is necessary for injection.

WHAT KIND OF HIGH IS IT? These drugs produce a drowsy, sleepy high that is like getting drunk in some ways. Users often walk into walls, or other people, or trip over objects because they become very uncoordinated and do not notice. After taking any of these drugs, there is usually a wave of sleepiness, which passes after awhile into an intoxicated state. Speech becomes slurred, and reflexes are so uncoordinated that doing things like driving and riding bicycles are extremely dangerous. This high lasts anywhere from two to 12 hours, depending on the drug and the amount taken.

Some barbiturates are made to be longer-acting, while some last for shorter periods. Secobarbital, the most popular, is one of the shorter-acting downers that comes on rapidly. None of these drugs are pain-killers, although they all dull the senses and this will somewhat dull the pain as well. They are all central nervous system (CNS) depressants.

WHO USES THEM? Barbiturates are used by people of all ages, both sexes, all races, and all economic groups. These drugs have been around for so long, and are used so widely in medicine, that users and abusers alike can be both young and old. Drugs are obtained legally by prescription, or illicitly on the streets, from neighborhood dealers.

ARE THEY ADDICTING? Yes. Barbiturates, and most other types of downer drugs, can be very addicting. Overdoses are also very common. As with other addicting drugs such as heroin, the user usually starts taking a small dosage, then slowly builds up to larger and larger amounts. However, this tolerance level builds even faster with barbiturates than with heroin. One pill may get the user high the first day, but usually by the very next day it will take two to feel the same way. Sometimes the amount taken gets to be up to 30 pills a day. Taking as many as six or eight, if you have no such tolerance level, may cause an overdose.

Also, taking a small number of barbiturates and drinking alcohol creates a condition in the body where each of these drugs potentiates the other, and creates a different kind of overdose. In this case the liver can only handle the alcohol at first, so the barbiturates keep re-circulating through the body, which the nervous system is not strong enough to handle. Accidental overdoses also happen this way with people who are taking "safe" amounts of a prescribed barbiturate, but who do not know that they cannot drink afterwards.

WHAT ARE THE MOST COMMON PROBLEMS FROM THESE DRUGS? Accidents, addiction and death are the most common problems. People who take downers become so unaware of what they are doing that they often put themselves in dangerous situations. In addition, these drugs make many users especially argumentive and disagreeable. Many fights and other types of violence happen by downer users who just can't control their emotions or tempers.

One thing about barbiturate addiction that is especially dangerous is that users who have built up a tolerance to these drugs have a certain "cut-off" level above which the body cannot handle, but they do not know what it is. A person may build up to needing 30 downers just to get high, for example, but 31 might kill him. (The level is completely different for every person.) By comparison, a heroin addict might start out using $10 worth of that drug and eventually build up his tolerance so that it may take 50 or even 100 times as much to get high.

A heroin addict also has many choices about getting rid of his addiction. He can kick the drug "cold turkey" by himself, or go to a hospital or clinic which may give him mild drugs to help ease the pain, or no drugs at all. Heroin addicts, in withdrawal, go through cold and hot flashes, sweating, nausea, vomiting, cramps and other unpleasant reactions which are almost all over within three days. A barbiturate addict will also experience all of these, but it is absolutely necessary that he be withdrawn from his habit in a hospital, under close supervision. This is because barbiturates can cause grand mal (large) convulsions when withdrawn suddenly after a heavy addiction, and those can cause death if you try to kick by yourself. Heroin addicts and alcoholics also get these convulsions, but only rarely — usually they are of the lesser "petit mal" type, which are not deadly. Also, unlike heroin addicts or alcoholics, a barbiturate addict may have these larger convulsions up to 14 days after withdrawal of the drug.

Many people accidentally overdose because they are trying to get high, but they lose track of how many downers they have taken. After awhile it becomes very confusing, so some users keep taking a couple more, "just to make sure" they stay high.

Most people who become addicted to downers do not mean to get strung out. They take them thinking that their depression will go away, or because they do not want to face problems. Or they may just know a lot of other people who take them. Or, they may be getting a prescription from a doctor and believe, falsely, that "if I take twice as many I will get well twice as fast," and so on. Whatever the reason, whenever the dose becomes regular, and starts to increase, the user is headed for trouble.

These drugs are not perfect ones, even when taken for sleep. They do not allow the user to fall easily into the deeper types of restful sleep that are so necessary for the rejuvenation of the body and mind after a hard day. Still, doctors prescribe them because no sleep at all is even worse for you than sleep that is not quite perfect. They are ideally used in medicine only for short periods of time, however, since after weeks or months of use, sleep may become almost impossible without them. Many people become "habituated" to barbiturates as well; this means that, while they are not taking enough to become addicted, they cannot feel normal without the drug, either.

So, to sum it up, barbiturates may seem at first to be mild, pleasant drugs which act a lot like alcohol in terms of the way they can make a person feel high. But overdose is extremely easy, especially in conjunction with alcohol (or other types of downers, and heroin). The addiction is a special one that is easy to slip into, and very hard to break out of. They give the user a nasty temper, in many instances, and lead to many accidents. They are illegal as well, unless they are obtained by prescription, and sometimes may be dangerously or poisonously made if they come from illegal laboratories. (If illegally made, the user also does not have any idea of the strength of each dose.)

With all this information, it may be hard to understand why so many people continue to use them. Possibly the answer is that some people are looking for an easy way out of their problems. This just never happens in real life — and usually, the problem comes back the next day, even worse than it was to begin with. It is also true that some people get into downers without knowing about all the possible dangers. There is much, much more information available in print on the subject, and this fact sheet is only a start. Learning more about these drugs would be a very good idea.

One particular barbiturate — phenobarbital — is different from all of the others mentioned. It is a very mild tranquilizing drug, and not as likely to produce addiction, overdose, or intoxication.

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SENATOR [illegible] DISTRICT

State of New York
COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION
Office of Alcoholism and Substance Abuse

Alcohol and Substance Abuse Fact Sheet Series

PHENCYCLIDINE FACT SHEET

P.C.P. and ANGEL DUST

What is it? PCP is an anesthetic that has been used mostly on animals. It deadens the limbs of people who use it, but feels like a type of psychedelic to the mind.

What does it look like? It is a white powder in its pure form. It can be made into tablets or capsules, and color can sometimes be added. It can also be sprinkled on other substances and smoked -- such as mint leaves.

How is it used? PCP can be eaten (ingested), or smoked (on mint leaves, or even such things as tobacco or marijuana). It can also be snorted (sniffed) or shot up (injected), though it is seldom used this way.

Is it dangerous? Yes, in many cases. There is an overdose potential. It can cause memory lapses. Loss of feeling in arms and legs can lead to many accidents because limbs are uncoordinated with mind.

How many people have tried PCP? In the United States, about 7 million have taken this drug, according to government estimates.

Is it illegal? Yes. PCP is illegal in all states, and many foreign countries as well. Penalties are different in every state, however.

You may have heard this drug called various names. It may come as a powder, or in a tablet or capsule form sometimes. It is also mixed with mint leaves and smoked. It may be called PCP, Angel Dust, Rocket Fuel, KJ, CJ, Embalming Fluid, Angel Hair, 'Tic,' Crystal, Crystal Weed, Super Weed, and other names, depending on where you live and what your local dealer has decided to call it.

Sometimes PCP is also sold as THC, which is supposed to be synthetic marijuana. Real THC is much too expensive to produce. Almost every time THC is sold it turns out to be PCP. There is also no such drug as 'Cannabinol.' This, also, almost always turns out to be PCP. When THC and Cannabinol are not PCP (which is very rare), they may contain other drugs such as weak LSD, or a downer, or nothing at all.

Besides hearing about PCP from friends, you may have heard about PCP on the news, or have read somewhere that it is a big problem. What are the actual facts?

It is true that many PCP users, both those who swallow this drug and those who smoke it, may get high and then come down with no problems. But it is also true that many others experience very serious problems. This drug can cause the user to have complete memory lapses when stoned. This means that when some people smoke Angel Dust, for example, they may have a really horrible experience of some kind, then remember only a good trip when they come down.

This lack of memory would not be such a bad thing except that many people go on and on time after time, thinking that this is a safe drug. The more often it is used, the stranger the reactions become. Researchers feel that many people who smoke Angel Dust or take PCP may have permanent damage to some parts of the brain. Other researchers feel that this damage may go away eventually. The problem is greatest with people who use the drug over and over again, over a period of months to years.

People who use any form of PCP have some very serious things to keep in mind. First, this drug can cause an overdose and death if too much is taken all at once (either eaten or smoked.) Second, PCP makes you do things you would never do if you were stoned on a different drug. These things are often completely opposite anything you believe. Most of these experiences are never remembered, though. This makes some PCP users believe that their friends are telling them lies about what really happened when they were stoned.

Third, PCP causes the loss of control or feeling in the arms and legs. This is because it is also an anesthetic, and was once used in experiments to deaden the pain during operations on humans. However, many people had reactions that were so strange that the drug became a tranquilizer for animals instead. Now it is no longer legally available even for animals.

This loss of control of the arms and legs is very serious, since at the same time your mind is still working, and it is easy to imagine that everything is normal. So you may think you can swim, or walk or run, or perform complicated tasks. In reality, most of the time you are very uncoordinated when using PCP or Angel Dust. Many users have drowned, or have gotten into fatal car accidents because of this drug. Your arms and legs do not do what your mind tells them to.

Paranoia is very common for people who get stoned on PCP. This means that people become scared of just about anything, such as a policeman asking for I.D., or someone looking into a window at them, when there is nobody there. It is more than just a little nervous - it may be completely terrifying, and have a long-lasting effect on the user, who must then be hospitalized. Other times, terrifying experiences just disappear and are forgotten when the person comes down.

Because PCP is an anesthetic, sometimes stoned people cut up their hands or bodies on sharp objects and do not realize that this has happened until hours later. Accidental deaths by bleeding have also happened this way.

All this may sound like PCP is the worst drug in the world. Some people think that it is. Others believe that no drug could be this bad. Some of the things people say about PCP and Angel Dust sound like scare stories that are made up to keep anyone from wanting to try this drug even once. Why is this?

In the past, when a new drug has been invented, or was publicized in the news, people often started to panic and invented scare stories to prevent others from wanting to try it. This has happened in the past with marijuana, Codeine cough syrup, glue sniffing, and other drugs. When one person made up a scare story, many other people were often willing to believe it because they did not know any better. Even today many people do not know all the true facts about such drugs as LSD, and sleeping pills, because of wrong information in the past.

With PCP, however, there is no reason for anyone to invent such scare stories. All of the problems talked about here are real, and are not made up or exaggerated to make them sound worse.

PCP is not necessarily always a bad drug, if used properly in certain ways. A drug related to PCP, called Ketamine, is considered a very good anesthetic for certain human operations. Veterinarians still feel that PCP can be a useful drug for animals sometimes, even though it is no longer available.

This drug causes your mind to have delusions, and distorts thinking and your senses of hearing, vision, touch, smell, and so on. It does not cause true hallucinations, though. It is not a psychedelic drug, and it is not related to drugs such as LSD, mescaline, or marijuana.

You can overdose on PCP if you are also drinking alcohol, or taking certain drugs such as barbiturates or other downers. Many people who work in drug crisis centers feel that PCP causes more bummers in more people than any other drug. These are people who have spent years and years treating all sorts of drug problems. Some drug experts think that the risk of having a bad experience on PCP is a hundred times greater than having a bad trip on a psychedelic such as LSD.

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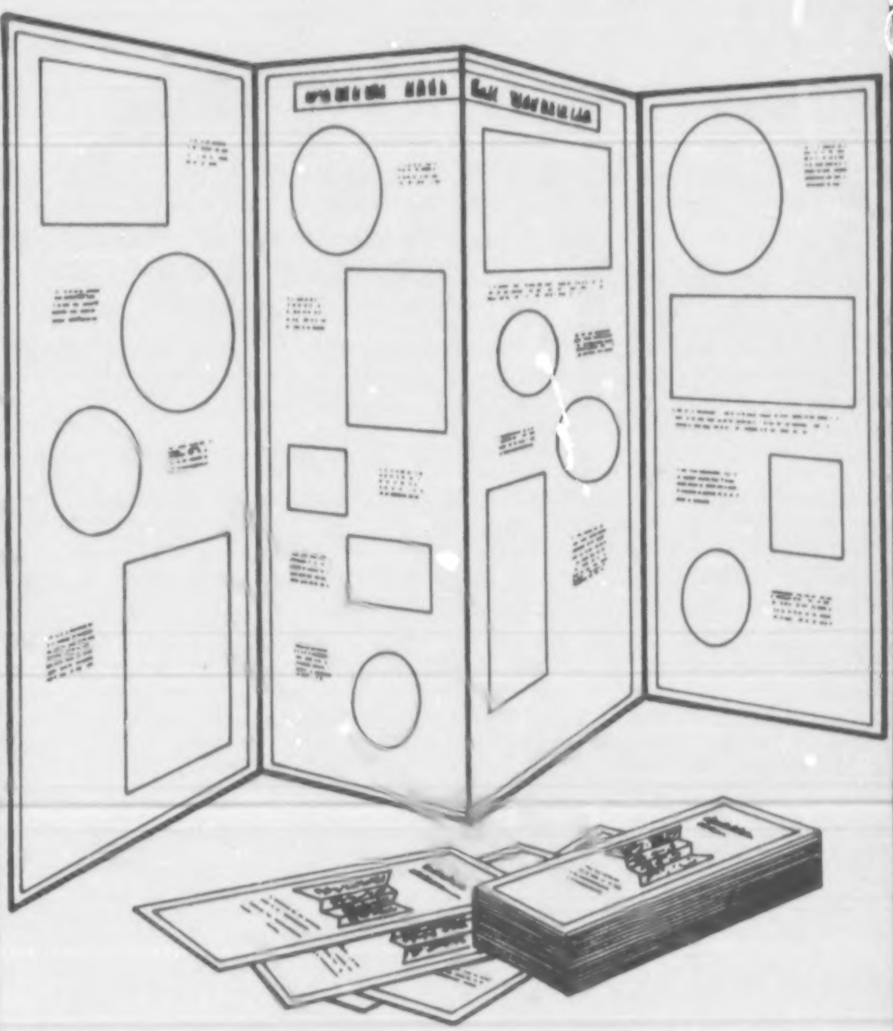
HO-5

HAZARDS OF DRUG ABUSE

BY W. R. SPENCE, M. D.



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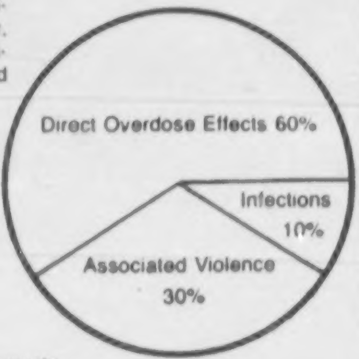
Every drug is a potential poison which can cause disability and death if it is taken incorrectly into the body, consumed in the wrong amounts or mixed indiscriminately with other drugs. The common types of abused drugs can be divided into 7 categories:

1. DOWNERS
2. UPPERS
3. NARCOTICS
4. HALLUCINOGENICS
5. INHALANTS
6. MARIJUANA
7. ALCOHOL



Drug Abuse Deaths

1. DOWNERS

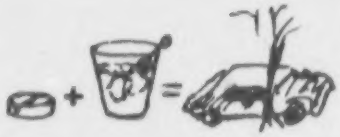
Barbiturates, nonbarbiturate sleeping pills, muscle relaxants, tranquilizers, and many antihistamines fall into this category. Downers belong to a group of drugs used to relax or sedate the central nervous system.

CYANOSIS

The fast acting barbiturates, such as Seconal and Nembutol, are the most dangerous of the downers. They can cause overdose death by paralyzing the portion of the brain controlling respiration. Depressed breathing, cyanosis, heart failure, and respiratory arrest are signs of severe downer overdose.

DOWNERS AND ALCOHOL

Mixing of downers and alcohol is one of the most common causes of accidental overdose. These drugs affect each other, and the speed at which the brain, heart, and respiratory systems are depressed is greatly increased. These drugs should never be taken together.



BRAIN DAMAGE

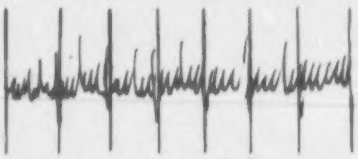
Irreversible damage to the brain is the common problem seen with downer-alcohol overdose. Patients may linger days or years in a coma and never regain consciousness or the ability to think normally.

2. UPPERS

Amphetamines are the most widely abused uppers. These drugs stimulate the central nervous system and produce excitability, rapid and unclear speech, breathlessness, tremors, sweating, increased pulse and blood pressure, and insomnia.

DEPRESSION

Stimulants do not produce physical dependency as do narcotics, but as they wear off the patient is prone to suffer a rebound depression. This depression may be so severe as to cause suicide.



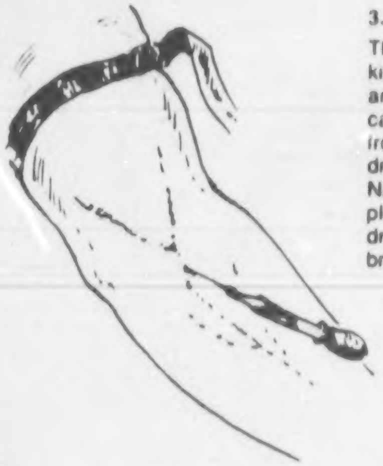
PSYCHOSIS

Stimulants can produce serious psychotic states which mimic other mental illnesses, such as schizophrenia. Many automobile, industrial, and social accidents are related to reckless and bizarre behavior from the influence of uppers.

INSOMNIA

Inability to sleep is one of the most serious side effects of stimulants. Abusers may go days at a time without normal sleep. If this is not quickly corrected, psychotic states will result.

HAZARDS OF



3. NARCOTICS

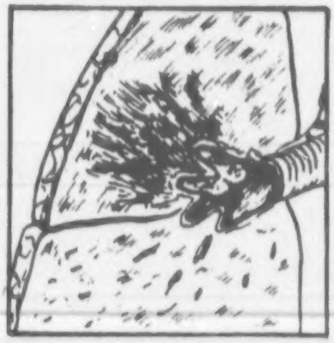
The term narcotic generally refers to opium and pain-killing drugs made of opium, such as heroin, morphine, and codeine. Codeine is classified legally, but not medically, as a narcotic drug. Heroin, a white powder made from morphine, is the most important of the illicit narcotic drugs. It is not used in any form of legal medical practice. Narcotics depress the brain and result in feelings of pleasure, strength and superiority, followed by lethargy, drowsiness, confusion and depression of the heart and breathing.

BLOOD CLOTS

When an addict's veins are repeatedly punctured, particularly by unsterile needles, blood clots and scarring may occur within the veins.

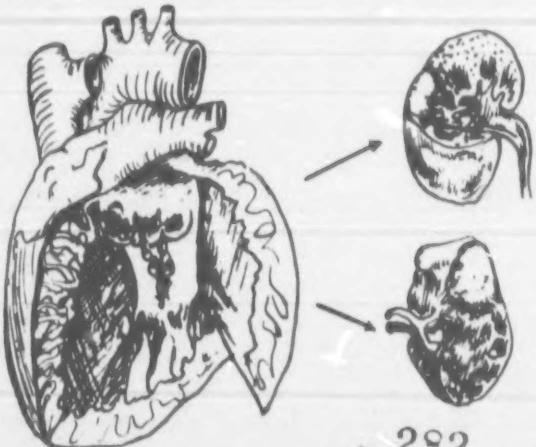
PULMONARY EMBOLISM

A dangerous complication can occur when blood clots in the veins of an addict's arms break off and float through the bloodstream to the heart and lungs. A well formed blood clot can be seen extending almost completely through the course of this pulmonary artery within the lungs. This patient will die because the blood clot has shut off blood going to the lungs.



BACTERIAL ENDOCARDITIS

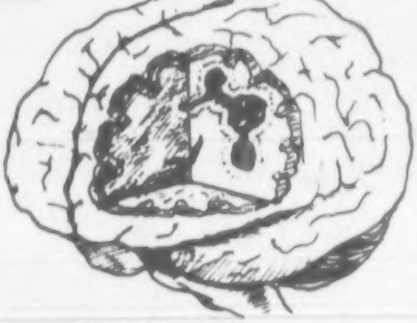
If germs enter the bloodstream from an unclean needle, they may spread throughout the body and lodge on the valves of the heart, causing a serious infection known as bacterial endocarditis. The warty-like growths seen on these heart valves produce symptoms of fever, weakness, heart failure, and death.



SHOWERS OF CLOTS

Tiny showers of clots and bacteria may be released from the growths on the infected heart valves and spread to the kidneys and spleen. The results of these showers are seen as multiple red spots in the kidney and as a grayish area of dead tissue at the uppermost portion of the spleen. This is usually a fatal complication in drug abusers.

DRUG ABUSE

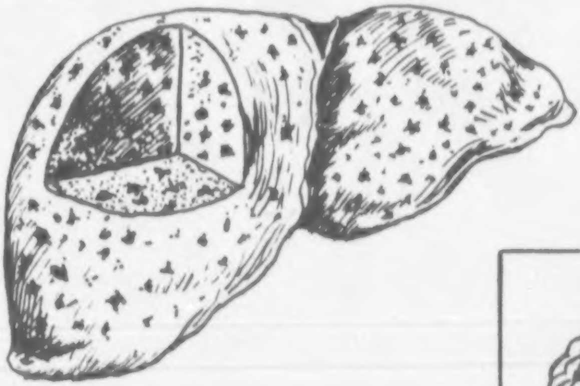


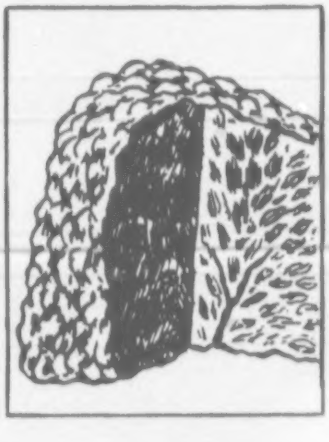
BRAIN ABSCESS

When germs are injected into the bloodstream from an unsterile needle they may travel through the body and lodge in the brain. In this illustration, note the ragged, abscessed cavity filled with pus. High fever, convulsions, coma and death are signs of a brain abscess.

SERUM HEPATITIS

Inflammation of the liver is one of the most common problems seen in heroin addicts. It is caused by a virus which is transmitted from one person to another through contaminated needles. The liver becomes swollen and irregular patterns of light-colored inflammation can be seen scattered throughout. Hepatitis causes weakness, loss of appetite, tenderness in the abdomen, dark colored urine and a yellowish change in the color of the skin and whites of the eyes.





CIRRHOSIS

The liver responds to any inflammation, such as hepatitis, by laying down scar tissue among its cells. When this scarring process progresses it is known as cirrhosis. The surface of the liver may become rough and wrinkled as a prune. Cirrhosis causes a variety of symptoms, including loss of weight, chronic nausea, vomiting, weakness, loss of sex drive, bloating of the abdomen and internal hemorrhaging.

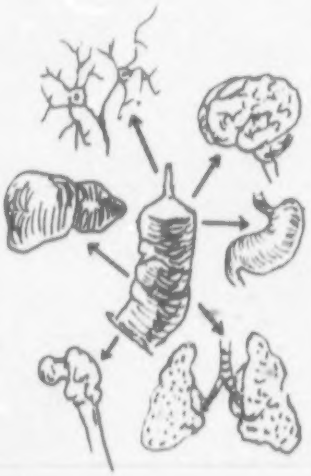
BIRTH DEFECTS

Children born to women who have taken drugs during their pregnancy may be stillborn or afflicted with multiple birth defects. This child has a right club foot, a missing right hand, a cleft palate and harelip, and internal abnormalities. Birth defects may be caused by many drugs. It is advised that pregnant women avoid all drugs, including alcohol, during pregnancies—particularly the first three months.

4. HALLUCINOGENICS

Hallucinogenic drugs are chemicals which produce hallucinations (seeing or hearing things not present). In practice, these drugs actually produce more distortion (seeing and hearing things in a different way) than hallucinations. They have no accepted use in medical practice. LSD, a white crystalline powder which is tasteless and odorless, is a most common hallucinogenic drug. It produces trance-like states, anxiety, confusion, tremors, euphoria, depressions, dilated pupils, increased pulse and blood pressure, as well as hallucinations.

All types of bizarre pleasant and unpleasant sensations may be caused by hallucinogenic drugs. Frightened, wild, uncontrollable behavior may occur if a person has immediate unpleasant effects from the drug or experiences a flashback to a previous "bad trip."



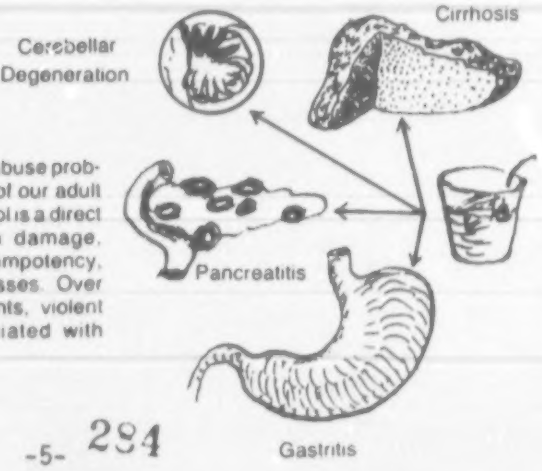
5. INHALANTS

Many organic solvents, such as airplane glue, gasoline, ether, thinner and aerosols, produce fumes which cause sensations similar to alcohol intoxication. But they also may result in serious and permanent damage to the nerves, brain, stomach, lungs, bone marrow and liver. Death from overdoses of "glue sniffing" are not uncommon.

STOP
STOP
STOP

6. MARIJUANA

Although it has been known for nearly 5,000 years, marijuana is one of the least understood of all naturally occurring drugs. It affects mood and thinking, much like alcohol, and may cause mild hallucinations. Serious physical damage from marijuana is uncertain at this time, but poor mental motivation, erratic driving and mechanical performance, decreases in body immunities, and possible damage to the sex organs are reported. The by-products of marijuana are stored in the liver, lungs, brain, spleen, lymphoid tissues and sex organs.



7. ALCOHOL

Alcohol is our number one drug abuse problem today. Approximately 10% of our adult population are alcoholics. Alcohol is a direct cause of liver disease, brain damage, stomach ulcers, pancreatitis, impotency, and many other physical illnesses. Over 60% of all automobile accidents, violent crimes and rapes are associated with alcohol.

TEST QUESTIONS

Take this exam before and after reading the text.

T F 1. Every drug in the world is a potential poison with distinct medical hazards.
T F 2. Antihistamines may be classified as downers.
T F 3. Alcohol and tranquilizers should never be taken together.
T F 4. Uppers may cause severe depression.
T F 5. Heroin is not used in any form of legal medical practice.
T F 6. An injection in the arm may cause an abscess in the brain.
T F 7. Hepatitis may lead to cirrhosis.
T F 8. Hallucinogenic drugs are chemicals which depress the brain and easily lead to overdose death.
T F 9. Marijuana has been known to mankind for nearly 5,000 years.
T F 10. Approximately 10% of all adults in the United States are alcoholics.

ANSWERS:

(1)T (2)T (3)T (4)T (5)T (6)T (7)T (8)F (9)T (10)T

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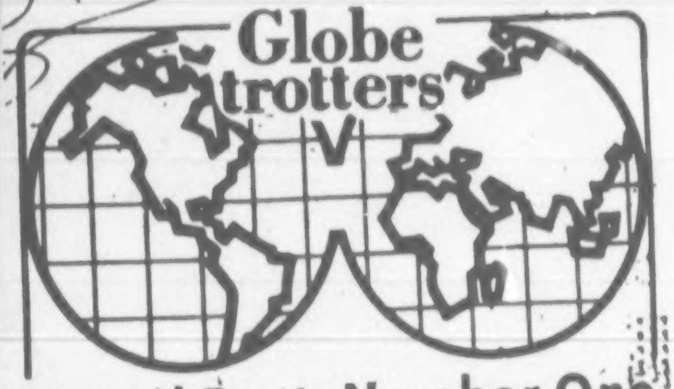


Angel Dust: Number One Cause Of Mental Illness?

By SETH ROSENFELD
Pacific News Service

LOS ANGELES, CA. — The diagnosis of paranoid schizophrenia fit the patient's behavior almost perfectly. But it was wrong.

His problem wasn't deep-seated mental illness at all. It was a common form of drug abuse which may be confused with schizophrenia in hundreds of thousands of cases around the U.S.

A person who suddenly, without warning, becomes violently psychotic could be suffering from the effects of PCP or angel dust, a powerful animal tranquillizer widely — and often unwittingly — smoked with marijuana, new findings suggest.

A new test, which allows detection of PCP residues at much lower levels than was previously possible, has shown that 80 of 100 patients admitted to Los Angeles County Hospital within the past 15 months had traces of PCP in their blood. At Los Angeles Metropolitan State Hospital, where the test was developed, more than a fourth of the psychiatric admissions were found to be PCP-related. The problem "would appear to be of epidemic proportions," according to Dr. George Simpson, laboratory director at Metropolitan.

PCP seems to catalyze violent behavior and often gives users a feeling of omnipotence and invincibility. It has been linked to extreme violence against self and others. Dr. Samuel Rappert, medical director of California's Camarillo State Hospital, said he believes "PCP is the most dangerous drug we've had around so far in terms of imminent danger to the person taking the drug and to other people."

The heavy casualties of PCP use are also a heavy public expense, for such patients require acute care, which can cost as high as $300 a ay, according to Dr. Orm Aniline, psychiatrist at Los Angeles County Hospital.

Though Los Angeles is known among drug abuse specialists as "angel dust capital of the world," the use of PCP (phencycladine) as a cheap illicit high is nationwide. And because marijuana is sometimes laced with it to increase potency, many smokers are exposed to PCP unknowingly.

At Detroit's Children's Hospital, Dr. Alan Done, director of clinical pharmacology, said that "for people who develop like a bolt out of the blue what appears to be totally unhearided paranoid schizophrenia, we're finding that somewhere close to half have PCP in their blood.

"This is the first chemical agent that has exactly mimicked paranoid schizophrenia in some people, and it appears to do so in people not otherwise destined to become schizophrenic," he said.

In the January, 1979, issue of the American Journal of Psychiatry, Dr. Arnold Rosen described the case of an outgoing high school student, and member of the basketball team, one week after he smoked some PCP, his "paranoid delusions" and extreme agitation became uncontrollable and he was hospitalized. His symptoms grew worse and became "indistinguishable from catatonic schizophrenia," Dr. Rosen wrote.

Though some who smoke the drug seem to suffer no serious after-effects, others try a small amount and wind up in a psychiatric ward for months. There they run another hazard: misdiagnosis. For if their condition is mistakenly perceived as naturally occuring schizophrenia, they may be given drugs that could prove fatal when they interact with the PCP in their body.

Dr. Steven Lerner, a clinical PCP researcher in San Francisco, reports the case of a man in his early 20s who was brought into an East Coast hospital extremely disoriented, violent and staring blankly. He was given Thorazine, a heavy tranquilizer used for schizophrenics. His symptoms subsided and he was released. But later, while this man was walking along a cliff, his blood pressure dropped suddenly because of a PCP-Thorazine reaction. He lost consciousness and fell to his death.

Diagnosis of PCP-induced psychosis is made more difficult by the fact that patients often cannot provide accurate information about their drug use.

"Maybe ten per cent of the people who flip don't know they've taken it because they got a spiked joint, and maybe 30 per cent deny they've taken it because they really don't remember, because amnesia is one of the symptoms of PCP," Dr. Simpson said. "So unless you pick something up from the clinical picture you could miss it."

The drugs of choice for PCP-induced psychosis are haloperidol (generic for Haldol) and diazepam (generic for Valium), according to Dr. Lerner. But he says the choice of treatment depends on degrees of PCP intoxication.

"Until we started doing some of this blood work, a lot of times you had patients acting in a bizarr way and you didn't know what it was caused by, said Dr. Aniline. "A lot of places that screen for PCP are missing people because their priliminary tests are not sensitive enough."

The test, developed at Los Angeles Metropolitan Hospital can detect PCP blood levels as low as 1.5 anagrams per milliliter, while standard tests usually fail to pick the drug up at less than 100 anagrams. A New Orleans hospital running standard tests found eight per cent of its patients to have PCP traces. After tests similar to those used at Los Angeles County, all 180 of its psychiatric patients screened werd found to be PCP-positive, according to Dr. Lerner.

In Detroit, Dr. Done said he believes PCP use is "an extremely important problem from the public health and sociological point of view." He said PCP patients seem to become "much more intensely paranoid, much more prone to become dangerous and violent" than ordinary paranoid schizophrenics.

"And the one thing they have that the paranoid schizophrenic doesn't have is the extreme strength and ability to withstand pain," he said. "So you put all these things together and it makes for a pretty explosive set-up." A Southern California man, who had smoked PCP-laced marijuana the night before, shot and killed his wife, fired a gun at his ten-year-old son and then at a passing bicyclist, reports Dr. Lerner. During the ensuing shootout with police, he advanced toward fire until he dropped from blood loss. He had no previous history of mental illness.

"The impacet (of PCP) on the psyche and behavior of the individual is much more dangerous than heroin," according to Dr. Rapport. "People can be totally unpredictable and extremely violent."

Drug-Related Deaths and Emergency Room Visits Reported for 1979

The following are National Institute on Drug Abuse estimates of drugs most commonly associated with deaths and emergency room visits in 1979, recently released. These conservative figures are based on information collected from areas representing about 35 percent of the U.S. population. Approximately 9,000 drug-related deaths and 289,000 emergency room visits were reported in 1979. Medical examiner drug mentions are preliminary.

DRUGS Generic Sample (Brand Names)	Estimated Emergency Room Mentions	Emergency Room Rank Top 20 Only	Estim. Deaths For Single and Combination Drugs	Medical Examiners Rank Top 20 Only	Estim. Deaths For Single Drug
Heroin Morphine	9,100	7	*830	5	180
Methadone	3,200		480	11	70
Codeine	3,000		630	7	60
Marijuana	11,400	6	50		10
Phencyclidine	15,000	4	290	15	140
Cocaine	7,100	13	350	13	100
Alcohol-in-combination	62,600	1	2,480	1	
Secobarbital (Seconal)	4,000		640	6	190
Seco Amobarbital (Tuinal)	6,300	15	530	9	180
Phenobarbital (Luminal)	7,000	14	620	8	130
Pentobarbital (Nembutal)	1,400		500	10	240
Amobarbital (Amytal)	600		270	16	30
Diazepam (Valium)	46,400	2	870	4	40
Chlordiazepoxide (Librium)	7,200	12	120		10
Chlorpromazine (Thorazine)	5,400	18	120		40
Thioridazine (Mellaril)	4,600		170	20	60
Flurazepam (Dalmane)	11,700	5	260	17.5	30
Methaqualone (Quaalude)	8,200	10	220	19	50
Ethchlorvynol (Placidyl)	4,900	20	400	12	70
Methapyrilene Scopolamine (Sominex)	5,700	17	10		10
Aspirin	16,700	3	300	14	100
d-Propoxyphene (Darvon)	9,000	8	950	3	220
Acetaminophen (Tylenol)	8,200	10	260	17.5	20
Amitriptyline (Elavil)	8,200	10	1,020	2	270
Diphenylhydantoin (Dilantin)	6,200	16	12-		10
Amphetamine	5,000	19	80		10

SOURCE: Drug Abuse Warning Network, January-December 1979

*From **ADAMHA News**, 6 (21) 1980*

SYMPTOMS AND EFFECTS OF DRUG ABUSE

I. Considerable interest in recognizing symptoms

A. No single, conclusive symptom to prove the use of drugs. One of the most frequent questions asked by parents and teachers is "How do I know whether my children are beginning to use drugs and what should I look for?"

B. Many interrelated symptoms.
Accurate diagnosis requires expert.

The following outline reviews some of the things which can be observed in a drug user, but keep in mind that any single symptom or group of symptoms may not mean that you have encountered a drug user. These same indications may have other causes and only an expert can be certain of the specific cause.

II. Symptoms of drug abuse

A. Social symptoms

1. Earliest symptoms, but most frequently overlooked
   - a. Will normally be apparent long before there are indications of actual physical change brought on by drug use.
   - b. Unless a youngster is actually observed using a drug, or shortly thereafter, these physical indications may only be noticeable until the user is far advanced in his drug habit.
   - c. Social symptoms appear much earlier but are frequently unrecognized or ignored.

2. "Change" is most consistent type of social symptom
   - a. Change in habits, behavior, appearance, and attitudes.
   - b. These changes may be brought on by many things other than drug abuse, but the sudden, unexplained onset of such symptoms should at least lead the concerned parent or teacher to be alert to other symptoms of drug abuse.
   - c. Parents and teachers are in the best position to observe such changes.

3. Kinds of changes and social symptoms.
   - a. Secretiveness
     1. Has he become secretive about his friends and activities?
     2. Does he invite his friends home or does he suddenly prefer to meet them on the street corner or at some unknown rendezvous?
     3. Does he appear to have some private business in which he suddenly disappears for several hours?

4. Does he have unlikely explanations for his behavior?

b. Vocabulary

1. Have a number of drug users' terms drifted into his vocabulary and that of his companions?

2. Stash, score, stick, red, connection, etc.?

c. Attitudes

1. Are his attitudes changing?

2. Is there a change in his values?

3. Does he ridicule people who he once respected... parents, teachers, coaches, policemen, clergymen?

4. Does he refer to most oldsters as squares?

5. Does he make fun of the standards of organizations which he used to like such as Boy Scouts, church, school, etc.?

d. School and Social Activities

1. Does he have less interest in school activities?

2. Has he dropped out of extra-curricular clubs and sports?

3. Has his social life become less active and is it confined to a small group of acquaintances?

4. Does he seem to be meeting many new people without forming lasting friendships with them?

5. Is he talking about the possibility of leaving school without graduating?

e. Employment

1. Does he have trouble finding and keeping jobs?

2. Does he show little interest toward the responsibilities of a job...often leaves too late to go to work, takes time off without cause, shows little interest in good performance?

f. Finances

1. Does he have an excessive need for money without explaining how it's being used?

2. Is he going without lunches and other needed expenses without explanation?

3. Are household articles mysteriously disappearing?

4. Has he suddenly "lost" expensive possessions such as radios, typewriter, rings, watches, etc.?

5. Is money missing from your purse or wallet?

6. Does he have expensive articles in his possession for a few days, explaining that he is "holding them for a friend"?

4. Combination of Symptoms should lead to further investigation

a. Don't make the mistake that any one of these symptoms alone is a certain indication.

b. However, a combination of these should lead to further investigation and particularly to awareness of more objective physical symptoms of drug abuse.

B. Physical Symptoms

1. Dangerous drugs

a. Person will attempt to conceal obvious physical signs of drug use.

1. Unlikely that he will appear in public while experiencing the effects of the drug.

2. If you do observe these physical symptoms, it is probably because of some miscalculation on his part.

3. Suspect this possibility if he obviously avoids contact with other family members or teachers.

4. He may feign illness, refuse to come to meals, lock himself in his room, be absent from school, etc..

- b. Depressants
    1. Initial effects of making the user relaxed and less alert or lethargic.
    2. Larger dose will cause him to appear sluggish and even intoxicated with slurred speech, unsteady gait and general mental confusion - no alcoholic odor.
    3. Advanced use produces a continual drowsiness and inability to concentrate.
- c. Stimulants
    1. Nervousness, talkativeness, lively self-confidence and excessive activity.
    2. Sleeplessness and loss of appetite.
    3. Continued use may produce loss of weight and distortions in time and space perception - visual distortions.
    4. Pupils may be dilated.
    5. After a peak of stimulation is reached, user may suddenly be propelled into depression or may lapse into unconsciousness even coma.

2. Marijuana
    - a. Effects similar to alcohol except less impairment to physical function.
    - b. User may avoid being observed while under the influence.
    - c. Pot Smoker - unpredictable in behavior.
        1. Actions will vary from hilarity, talkativeness and general animation to depression, stupor and incoherency depending on length of time of use.
        2. Immediately following use eyes may be red, watery, and dilated.
        3. Continual use - may produce marked pallor and user will be drowsy during the day and very difficult to arouse.
        4. May develop badly stained fingers, similar to nicotine stains, and his clothing may have an odor of burning hay or leaves.
3. Volatile Chemicals
    - a. Chronic glue sniffers and experimentors with other volatile substances will frequently carry the odor of these substances with them.
    - b. Likely to suffer from nausea and loss of appetite.
    - c. Under the influence they will appear to be drunk or lightheaded.
    - d. Continued use may lead to inability to concentrate, fatigue, loss of weight and possibly inflamation around nose and mouth.
4. LSD (Lsyergic Acid Diethylamide)
    - a. The most difficult physical symptoms to detect are those associated with the use of this drug.
    - b. Except during the period that the use is actually under the influence, there is practically no outward indication of its use.
    - c. Only observable signs might be a quickening of respiration and pulse and dilation of the pupils of the eyes.

d. Psychological effects of LSD may produce noticeable changes in personality and behavior patterns so that the subtle social indications produced by other drugs become quite obvious in the LSD user.

5. Opiates and Heroin
    a. Few outward indications unless user is actually observed while under the more immediate effects of the drugs - detection of opiate user is difficult even for experienced law enforcement officers.
    b. Because of cost and other factors, opiates are not commonly used by teenagers, but when they are, they usually involve older teens.
    c. Common "social symptoms" discussed previously occur in the opiate user - other drugs should be suspected first.
    d. Heroin is injected - small needle marks may be found on arms or other portions of body.
        1. Minute, reddish pimples at first.
        2. Continued use will produce infections, scars and discoloration.
        3. Skin sores may develop and user may continually wear longsleeved clothing to hide these conditions.
    e. Heroin user likely to lose weight and his eyes will appear sunken and dark.
    f. During use, the pupils will be constricted, but as effects wear off the pupils dilate and it may be necessary for him to wear sun glasses constantly to protect his eyes.
    g. Symptoms of onset of withdrawl.
        1. Similar to onset of cold or flu.
        2. Yawning, sniffles, watering eyes and nose, and sneezing.

C. Other symptoms
    1. Social and physical symptoms are not the only indications of drug use.
    2. Many other more pronounced psychological and physiological effects which appear after prolonged use.
    3. These symptoms are more properly the concern of the medical practitioner and psychologist and will not be discussed here.

D. Mechanical indications
    1. Multitude of objects and paraphernalia associated with drug use.
    2. Types of equipment employed to package, transport, conceal, and consume drugs:
        a. Empty gelatin capsules - containers for various drugs in powder form.
        b. Cigarette papers -used to roll marijuana cigarettes.
        c. Bits of tin foil - wrappers from rolls of benzedrine tablets.
        d. Hypodermic syringe - occasionally used for heroin injections.
        e. Eye dropper - common substitute for syringe in heroin use.
        f. Plastic bags - used as waterproof containers for several types of drugs including powders, pills and pot.

g. Rubber ballons - same as above
h. Small folded papers - containers for durgs, especially heroin.
i. Crushed green substances resembling oregano - may be oregano or marijuana.
j. Small, shiny oval seeds - may be marijuana seeds.
k. Electric wire clips with fancy handle - may be holder for marijuana cigarette butts (roaches).
l. Bongs or ceramic pipes for smoking marijuana.

Drugs And Pregnancy

The drugs a woman takes during pregnancy and childbirth might harm her child. Even over-the-counter medicines can be a cause for concern. A pregnant woman should take drugs only when absolutely necessary and only on her doctor's advice.

by Pauline Postotnik

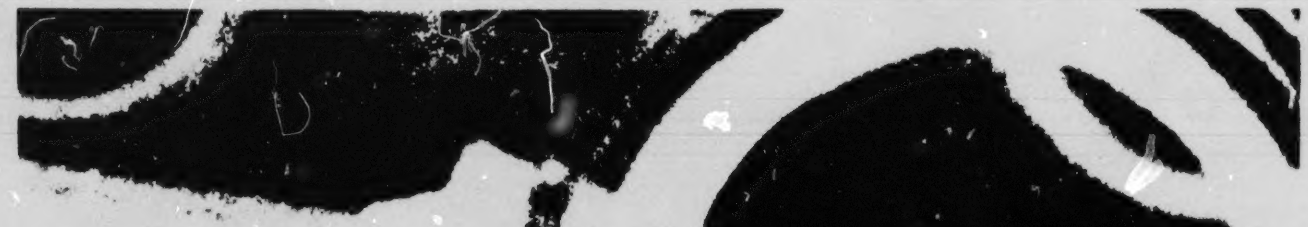
Are you pregnant or do you think you might be? Do you know anyone who is pregnant or who might be anticipating pregnancy in the future? If the answer is yes to any of these questions, you should be aware that some drugs taken during pregnancy can adversely affect the mother or her baby.

Many women have a healthy skepticism about taking drugs when they are pregnant. Unfortunately, however, we have become a nation of "pill poppers," taking medicines for minor aches and pains without really thinking about them. Thus some pregnant women take drugs, both prescription and over-the-counter preparations, for minor conditions such as colds, coughs, or nervousness when use of such drugs may not be necessary.

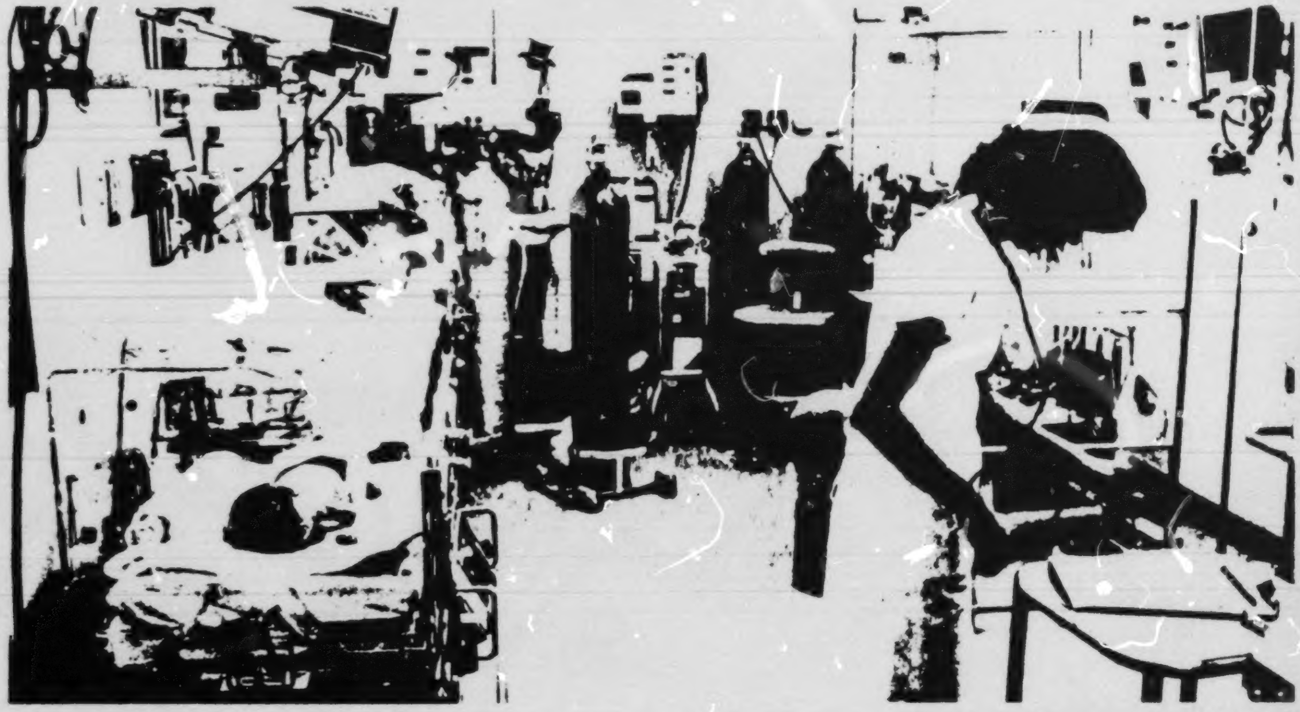
Some drugs can be beneficial to mother and child. Indeed, many infants owe their survival to drugs given to the mother during pregnancy. It is important to understand, however, that there are risks as well as benefits with any drug a person takes. Although scientists do not know the effects of all drugs on the unborn child, they have pinpointed a number which should be avoided by pregnant women.

A drug taken by an expectant mother enters her bloodstream and in most instances passes through to her unborn child. At one time it was believed that the placenta served as a barrier to protect the fetus from the effects of drugs taken by the mother. But it is now known that most drugs pass through the placenta, enter the fetus, and are eventually eliminated by passing back into the mother's circulatory system. Whether the fetus will be harmed depends on the nature of the drug itself, the time during pregnancy the mother takes it, and the amount of drug to which the fetus is exposed.

Physical defects can be caused in an unborn child by drugs taken by the mother during the early stages of pregnancy when the cells of the fetus are rapidly growing and organ systems are developing. The most publicized example of this danger occurred during the late 1950's and early 1960's with the drug thalidomide, a supposedly safe sedative that was sold without prescription in Germany and England. Widespread use of the drug resulted in thousands of infants being born with deformed limbs or no limbs at all.



Some pregnant women take drugs, both prescription and over-the-counter preparations, for minor conditions such as colds, coughs, or nervousness when use of such drugs may not be necessary.



Thalidomide was never approved by FDA for sale in this country.

The use of the hormones estrogen and progestin during the first 3 or 4 months of pregnancy can increase the risk of birth defects, including limb and heart defects. Estrogens used during pregnancy also increase the risk of female offspring developing a form of vaginal or cervical cancer that is ordinarily extremely rare. Both hormones formerly were used to prevent miscarriage; progestins also were used as a test for pregnancy.

FDA now requires that women taking estrogens be given a brochure which contains information about these possible fetal effects, and has proposed that similar information be provided on progestins. The information manufacturers supply to physicians about progestins also will be required to warn that they should not be used in early pregnancy or as a test for pregnancy.

Because estrogens and progestins are used in oral contraceptives, a woman who becomes pregnant (or who thinks she may have become pregnant) while taking oral contraceptives should stop using them immediately and consult her physician. Women who discontinue The Pill in the hope of becoming pregnant should wait at least 3 months before attempting to conceive and should use another method of contraception during the waiting period. A fetus conceived immediately after discontinuance of The Pill could have a higher risk of birth defects.

A number of other drugs are associated with fetal damage. Cancer drugs can cause serious birth abnormalities. Antibiotics of the tetracycline class should be avoided during pregnancy because they have been shown to cause permanent discoloration of the child's teeth.

Other drugs are suspected of causing some serious adverse effects on the fetus. These are drugs for which there is no firm evidence of fetal harm, but they continue to raise controversy among experts. Included among these drugs are the barbiturates. Pregnant women who have taken large doses of barbiturates throughout pregnancy or in the last 3 months may run the risk of giving birth to infants who show signs of addiction to barbiturates. Amphetamines, taken by many women to aid in weight loss, also may have the potential to cause birth defects.

Minor tranquilizers, such as Valium,

Librium, Miltown, and others containing meprobamate or benzodiazepine derivatives, when taken by a mother during early pregnancy, may increase the risk that her baby will be born with a cleft lip or palate. The information manufacturers provide physicians about these drugs now includes a warning about this possible danger. Similar birth defects may be associated with anticonvulsant drugs administered for epilepsy, such as phenytoin.

Aspirin and other drugs containing salicylate should not be taken during the last 3 months of pregnancy except under a doctor's supervision. Salicylate, a common ingredient in many over-the-counter painkillers, may prolong pregnancy and labor and may cause excessive bleeding before and after delivery.

In general, live vaccines such as rubella, measles, mumps, smallpox, yellow fever, and live oral polio vaccine are not recommended for pregnant women since the effects on fetal development are unknown at this time. Killed or inactivated vaccines such as influenza, rabies, cholera, tetanus, diphtheria, and Salk polio vaccine should be administered only when clearly necessary.

Although drugs can play a role in fetal damage, it is still uncertain how frequently they are responsible. It is often difficult to prove a cause-effect relationship in humans for a number of reasons. In the first place, many women do not realize they are pregnant during the first few weeks and may not keep track of the drugs they take at that time. While some physical defects of a newborn can be recognized at birth, others such as heart and kidney problems or mental retardation may not be apparent for months to years after birth when a mother may not be able to remember what drugs, if any, she had taken during pregnancy.

Furthermore, drugs are not alone in causing birth defects. Abnormalities also can be caused by genetic or inherited factors, by exposure of the unborn child to x rays, and by diseases such as German measles that the mother may get during pregnancy.

One of the most common causes of fetal damage is alcohol, which drinkers rarely recognize for what it is—a powerful drug. The more a pregnant woman drinks the greater her risk of giving birth to an abnormal baby. Studies show an increased frequency of stillbirths, premature babies, mental retardation, physical deformity, and behavioral problems among children born to alcoholics. The National Institute of Alcohol Abuse and Alcoholism says there is a definite risk of birth defects when a pregnant woman drinks 3 ounces or more of alcohol a day. Drinking 1 to 3 ounces of alcohol a day may be risky and caution is advised. Birth defects resulting from drinking during pregnancy are known as fetal alcohol syndrome.

Smoking by a woman also can have an effect on her unborn child. Heavy smoking increases a woman's chances of having an infant of less than normal birthweight.

Modern medicine has contributed greatly to alleviating some of the pain of childbirth. But no drug has been discovered that will give 100 percent relief from pain without adding to the risk faced by mother or child. Under normal labor and delivery (without any medication), infants are subjected to varying degrees of oxygen deprivation. Usually the child tolerates this brief "hypoxia" without difficulty. But a significant reduction of the oxygen supply during labor may reduce the infant's ability to breathe. It is known that drugs used to kill pain during delivery can depress the respiration of the newborn, just as they do the mother's. FDA requires that the labeling for meperidine (Demerol), a narcotic commonly used to relieve pain, inform physicians that its safety in pregnancy has not been established and that it may depress respiration in the newborn if used during labor.

Oxytocic agents—drugs which stimulate the uterus to contract—have been used for many years to induce labor and to reduce bleeding after delivery. There are instances in which induction of labor is necessary for the safety of the fetus and mother, such as when a woman has diabetes or hypertension. The effect of drug-induced labor is similar to that of natural labor except that the uterine contractions caused by the drug can be stronger and more frequent. During contractions, the blood vessels which bring the blood supply to the placenta are compressed, reducing the amount of oxygen going to the fetus. It is possible that the fetus can suffer from prolonged lack of oxygen resulting in damage to the brain and other organs.

After careful review, FDA's Obstetrics and Gynecology Advisory Committee has concluded that drugs should not be recommended for use to induce labor except when it is medically necessary for the safety of the mother or baby. Drugs sometimes are used to induce labor because a woman prefers for reasons of convenience to have her baby before natural labor is expected to begin. This is known as "elective" induction and the advisory committee said it is not clear whether the benefits of using drugs for elective induction outweigh the risks.

The committee suggested that FDA no longer permit the manufacturers of labor-inducing drugs to recommend their use for elective induction. FDA held a public hearing in June on this recommendation to allow those concerned with elective induction an opportunity to express their views. Final action will be taken after all comments are reviewed.

Thiazide diuretics have been used widely in the past to treat edema, or swelling caused by excess water retention, associated with pregnancy. The proper use of diuretics was discussed at an open meeting of FDA's Obstetrics and Gynecology Advisory Committee and as a result the information manufacturers provide physicians (called physician labeling) has been revised. The physician labeling now emphasizes that diuretics do not prevent toxemia of pregnancy and that edema during pregnancy is common and usually needs no treatment other than such measures as elevating the legs or wearing support hose.

All drugs approved for marketing by FDA have been tested in human volunteers for safety and effectiveness. Most drugs have not been tested specifically for safety during human pregnancy, however, because such testing would subject unborn children to unacceptable risks. But FDA has taken steps to protect the expectant mother who may need some drugs during her pregnancy.

- Before a new drug intended for use by women of childbearing potential can be marketed FDA requires that it be tested in animals to determine whether it could cause birth defects.
- A recent FDA proposal would require that the physician labeling for all drugs include a section on use in pregnancy which would summarize the results of studies on birth defects to help doctors make benefit-risk decisions. On the basis of such studies manufacturers would be permitted to recommend the use of certain drugs during pregnancy, and would be required to state that certain other drugs should not be used during pregnancy. The proposal also calls for physician labeling to include information on the use of drugs by women who are nursing their babies. This information also will be included in any labeling for prescription drugs that is supplied to patients.
- FDA advisory panels, conducting a large scale review of the safety and effectiveness of over-the-counter drugs, have made recommendations for labeling of these products for use by women who are pregnant or think they may be.

Testing of drugs in animals for birth defects has limitations. There is always a risk that a particular drug may prove harmful to the human fetus even though it showed no effect in animals. It is only through careful monitoring of human experience with drugs that their effects on the human fetus can be identified with certainty.

A number of monitoring systems and studies, such as the Finnish Registry, the Atlanta Registry, and the Collaborative Perinatal Study of the National Institutes of Health, are gathering and analyzing information on birth defects. So far they have found no evidence of any very powerful and harmful drugs like thalidomide. But there is always a chance that such monitoring might not disclose all drugs that could be potentially hazardous to the unborn child. That is why it is particularly important for women who are pregnant to follow this advice:

- Take drugs only when absolutely necessary and only on your doctor's advice.
- If it is essential to your health to take a drug which is known to cause fetal damage, discuss with your doctor whether you should terminate your pregnancy.
- Avoid tobacco and alcohol.
- Remember that the use of drugs carries a risk to your baby. At the time of delivery, do not demand a pain-free experience.

Pauline Postotnik is a consumer education specialist with FDA's Bureau of Drugs.

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FDA
CONSUMER

U.S. DEPARTMENT OF HEALTH,
EDUCATION, AND WELFARE
Public Health Service
Food and Drug Administration
Office of Public Affairs

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Eye-on-Crime
Narcotics Identification Chart

DRUG USED	PHYSICAL SYMPTOMS	LOOK FOR	DANGERS
Glue Sniffing	Violence, Drunk Appearance Dreamy or blank expression	Tubes of glue, Glue smears, Large paper bags or handkerchiefs	Lung/Brain/Liver damage, Death through suffocation or choking, Anemia
Heroin (H., Horse, Scat, Junk, Snow, Stuff, Harry, Joy Powder) **Morphine** (White Stuff, Miss Emma, M., Dreamer) **Codeine** (Schoolboy)	Stupor/Drowsiness, Needle marks on body, Watery eyes, Loss of appetite, Blood stain on shirt sleeve, Running nose	Needle or hypodermic syringe, Cotton, Tourniquet—string, Rope, Belt, Burnt bottle, Caps or spoons, Glassine envelopes	Death from overdose, Mental deterioration, Destruction of brain & liver
Cough Medicine Containing Codeine and Opium	Drunk appearance, Lack of coordination, Confusion, Excessive itching	Empty bottles of cough medicine	Causes addiction
Marijuana (Pot, Grass, Locoweed, Mary Jane, Hashish, Tea, Gage, Reefers)	Sleepiness, Wandering mind, Enlarged eye pupils, Lack of Coordination, Craving for sweets, Increased appetite	Strong odor of burnt leaves, Small seeds in pocket lining, Cigarette paper, Discolored fingers	Inducement to take stronger narcotics
LSD (Acid, Sugar, Big D, Cubes, Trips) **DMT** ('Businessman's High) **STP**	Severe hallucinations, Feelings of detachmant, Incoherent speech, Cold hands & feet, Vomiting, Laughing & crying	Cube sugar with Discoloration in center, Strong body odor, Small tube of liquid	Suicidal tendencies, Unpredictable behavior, Chronic exposure causes brain damage
Amphetamines (Bennies, Dexies, Co-Pilots, Wake-Ups, Lid Poppers, Hearts, Pep Pills)	Aggressive behavior, Giggling, Silliness, Rapid speech, Confused thinking, No appetite, Extreme fatigue, Dry mouth, Shakiness	Jar of pills of varying colors, Chain smoking	Death from overdose, Hallucinations
Barbiturates (Barbs, Blue Devils, Candy, Yellow Jackets, Phennies, Peanuts, Blue Heavens, Goof Balls, Downs)	Drowsiness, Stupor, Dullness, Slurred speech, Drunk appearance, Vomiting	Pills of varying colors	Death from overdose, Unconscious

3

(over)

WHAT CAN PARENTS DO?

With the right approach, parents often can help youngsters avoid drugs. Here are some guidelines that may prove valuable:

1. Many youths turn to drugs because they feel life is meaningless. Parents whose primary goals in today's world are to amass material possessions often contribute to this feeling. Growing youngsters need meaningful ideals and priorities, such as service to others and to emulate healthy people.
2. The selfish "gratification-now" outlook of many drug users may reflect parental attitudes. Parents who are unwilling to set limits for their children or who indulge them with everything may well find them growing up without a feeling of responsibility or self-discipline.
3. Parents must set a good example. The parent who reaches for a tranquilizer to meet every crisis or who drinks heavily for recreation is in a poor position to argue with a youngster who is "turning on" with drugs for fun or escape.
4. Parents should take time to inform themselves about the drug scene.
5. Parents should not overreact to a single or very few experimental trials with drugs with horror and rejection. Communication must be kept open so that the matter can be clearly discussed.
6. If a young person becomes a confirmed drug user, it is no favor to him to supply money for his habit. He should know, however, that his parents have not emotionally abandoned him. Parents should use every possible means to urge the youngster to seek professional help in stopping drug use.

A DRUG USER'S GLOSSARY

ACID: LSD-25, Lysergic Acid Diethylamide.

ACIDHEAD: a regular user of LSD.

BAG, DECK: Small packet of narcotics.

BAMS: Weak marijuana cigarettes.

BANG, FIX, SHOT: Injection of narcotics, usually heroin. "Fix" also means the dosage.

BLANK, DUMMY, TURKEY: Bag of non-narcotic powder sold as a regular bag.

BLAST PARTY: Group gathered to smoke marijuana.

BOMBITA: Vial of Desoxyn, an amphatamine (stimulant) sometimes taken with heroin for a stronger "high."

BOOST: Steal.

BREAD: Money.

BUM TRIP: A bad LSD experience.

BUNDLE: Twenty-five $5.00 bags of heroin.

BURINE: The butt of a marijuana cigarette.

BURNED: Rendered useless or vulnerable by recognition; e.g., "A narcotics agent was burned and unable to continue surveillance."

BUSTED: Arrested.

CAN (of marijuana): Between one and two ounces of marijuana ready for rolling into cigarettes; manicured marijuana.

COKE , SNOW: Cocaine.

CABALLO, DOO, JEE, HORSE, H, SCHMECK, TECATA, WHITE STUFF: Heroin.

CAN, SHORT, WHEEL: A car.

CAP: Capsule of narcotics or sometimes other drugs.

CHARGED UP, GOING UP, GROOVING, HIGH, TAKING A TRIP: under the effects of a drug.

CHIP, JOY POP: Use heroin in small amounts, or occasionally.

COKED UP: Under the influence of cocaine.

COLD TURKEY: Abrupt withdrawal from drugs without medication.

CONNECTION: Street peddler of narcotics; source of supply.

COOKER: Bottletop or spoon used for dissolving heroin in water over a flame.

COP, SCORE: Buy narcotics.

COP TO: Admit to something.

CRACKLING SHORTS: Breaking into cars.

CROAKER: Unscrupulous doctor who sells drugs or prescriptions to illict drug users.

CRUTCH: Device used for holding shortened butt of marujuana cigarette.

CUBEHEAD: A regular LSD user, sugar cubes are one form of black market LSD.

CUT: To adulterate narcotics, as with milk sugar, mannite, quinine, or talc.

DEAL: To sell narcotics to addicts.

DEALER, PUSHER: Drug peddler.

DIRTY, HEELED, HOLDING: Possessing narcotics; if searched could be arrested.

DOPE, STUFF: Any narcotic.

DYNAMITE: Heroin of exceptional purity or any drug, even marijuana.

EIGHTH: Fifth of an ounce of heroin.

EYE DROPPER: Medicine dropper used with hypodermic needle as makeshift syringe. Most addicts actually prefer it to a syringe.

FIVE-CENT BAG: A $5.00 heroin fix.

FLASH OR TINGLE: A quick jolt of pain high in adbomen or across chest from heroin shot.

FLEA POWDER, GARBAGE, LEMONADE: Grossly inferior heroin.

FLIP: Go psychotic.

FREAKOUT: A bad LSD experience.

GETTING OFF, SHOOTING UP, TAKING OFF: Injecting narcotics.

GIMMICKS, KIT, OUTFIT, TOOLS, WORKS: Equipment for injecting drugs, principally heroin.

GOOFBALL: Barbiturate.

GRASS, GAG, HAY, POT, TEA, T, WEED, MARYJANE, MARI, MARY, MEZZ, MUGGLES, HEMP, MIGGLES: Marijuana.

GUIDE: A person who "baby sits" for the psychedelic user during a session.

GUN, NEEDLE, SPIKE: Hypodermic needle for injecting heroin.

HARD STUFF: Powerful drugs like heroin and cocaine.

HOOKED, ON THE NEEDLE: Addicted to narcotics, especially heroin.

HOPHEAD, HYPE: A drug Addict.

HOT SHOT: Poisoned heroin, or an unsurvivably high percentage of heroin, sold to someone suspected of informing and intended to kill him.

HOOKER, HUSTLER: A prostitute.

HUSTLE: Prostitute, or in large sense, the whole pattern of getting money, getting heroin, getting straight.

INFORMER,STOOL: An addict assisting police in arresting peddlers.

JOINT, REEFER, STOCK, STICK: Marijuana cigarette.

JOINT (the): Prison.

JUNK: Narcotics, usually heroin.

JUNKIE: User of narcotics, usually heroin.

KICK (the habit): Break the habit of using drugs.

KILO: Technically 2.2 pounds - a large amount of narcotics from a pusher's point of view.

M, MONKEY, MORPH: Morphine.

MADE: Recognized for what you are.

MAINLINE: Inject directly into a vein.

MANICURE: Prepare marijuana for use in cigarettes.

MEDICAL HYPE: A person who has become accidentally addicted during medical treatment for illness or disease; one who obtains bona fide drugs through doctors or hospitals.

NARCO: Narcotics detective.

NICKEL: $5.00 bag of narcotics or marijuana; also a five-year sentence.

OD, OVERJOLT: Overdose of heroin.

ON THE NOD: High on heroin just after a fix; becoming sleepy and going to sleep after a fix.

PACK: Twenty-five "reefers" - marijuana cigarettes.

PAD: User's home, place where he shoots up.

PANIC: Scarcity of drugs.

PIECE: One ounce of heroin; a gun.

PILLHEAD: Addict on pills.

PLANT, STASH, Cache (hiding or storing) of narcotics.

QUILL: Matchboook cover used to inhale narcotics. Powdered drug is placed in fold.

ROACH: Butt of a marijuana cigarette.

RUN: Period of addiction; e.g., "He had a six-month run."

SCRIPT: Doctor's perscription.

SHOOTING GALLERY: Place where addicts congregate to shoot up.

SIXTEENTH, SPOON: Sixteenth of an ounce of heroin.

SKIN POPPING: Intramuscular, or subcutaneous, injection of heroin.

SNIFFING, SNORTING, HORNING: To sniff narcotics through the nose.

SPEEDBALL: Heroin mixed with a stimulant like cocaine or amphetamine.

SPLIT: Run away.

SQUARE: Someone who does not use drugs.

STACK: More than one pack (25) of marijuana cigarettes.

STRAIGHT: An addict's feeling of well-being after taking drugs.

STRUNGOUT: To be addicted; more specifically, to be badly in need of a fix.

TASTE: Small quantity of narcotics usually given as a reward or favor.

TEN CENT PISTOL: Bag containing poison.

THE MAN, THE FUZZ, THE HEAT: Policeman or detective.

TORCH UP: To light a marijuana cigarette (they burn much more brightly than an ordinary cigarette). Torch is also being used for a marijuana cigarette.

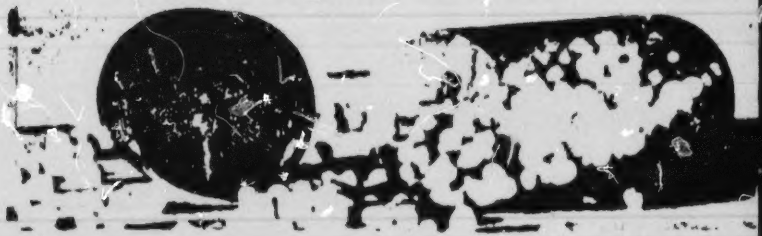
TRACKS: Veins collapsed by constant injection. Also needle scars from the injections.

TREY: $3.00 bag of narcotics, generally heroin.

WAKE-UP: morning shot.

What's in it?

by Stuart James, Toxicologist, Wilson Memorial Hospital



The greatest problem with street drugs is that one never knows what they contain. The user can never be sure of the amount or quality of the drug. There always is a high risk of a bad reaction, even death . . . if the user doesn't consider the purity of the drug.

Any individual confidentially can have a drug checked for contents by bringing a sample to the Narcotics Guidance Council or the High Hopes Drug Center at State University of New York at Binghamton. The sample is given a number and brought to the Toxicology (drug analysis) Laboratory of Wilson Hospital. Here, tests are run on the drug and the results are returned to the original place in one to three days. If a highly dangerous drug is found, the hospital's laboratory makes it known through the news media to warn drug users.

In a recent study done by the Toxicology Laboratory, it was found that 74% of the local drugs studied in the laboratory were mixed with other substances or didn't contain any of the drug people were told was in it. Some of the test results are:

- LSD is found in place of mescaline
- No mescaline has been found in tablet, capsule or powder form
- The amount of LSD varies greatly from 20-300 micrograms
- Usually added to LSD are amphetamines (speed), methamphetamines, barbiturates (barbs) or phencyclidine (PCP)
- PCP, an animal tranquilizer, sometimes is sold as synthetic (manmade) marijuana or mescaline.
- Heroin in this area is weak, averaging about three percent. It is commonly mixed with quinine, lactose and antihistamines.

How they say it... HO-11

The Drug Vocabulary Compiled by Volunteers of the Narcotics Guidance Council and the Toxicology Laboratory of Wilson Memorial Hospital

Acapulco Gold	— A high grade of marijuana originating in Mexico.
Acid	— Lysergic acid diethylamide (LSD).
Acid Head	— One who uses LSD regularly.
Amphetamines	— Stimulants (Speed).
Artillery	— Equipment used to inject drugs.
Bag	— A container of drugs.
Barbs	— Barbiturates.
Bennies	— Amphetamines.
Black Beauties	— Amphetamines.
Blow Your Head	— To experience severe mental effects from drugs.
Bomber	— A large marijuana cigarette.
Boot	— To draw blood from a vein to make sure the needle is in.
Bread	— Money.
Bummer	— To experience a bad trip from LSD.
Bundle	— A packet of drugs.
Burned	— To obtain weak drugs.
Busted	— To be arrested.
Buzz	— A feeling of exhilaration produced by a drug
Cannon	— A hypodermic syringe.
Cap	— A capsule.
Cartwheels	— Amphetamines.
Chippie	— A small habit.
Coke	— Cocaine.
Cold Turkey	— Withdrawal from an addicting drug without medication.
Come Down	— To lose the effect of a drug.
Connection	— A drug seller.
Cooker	— A spoon or similiar device used to dissolve a drug for injection.
Cop	— To buy a drug.
Crash	— To come down from a high.
Cut	— To dilute a drug.
Crystal	— Street name for Amphetamines.
Dealer	— A person who sells drugs.
Dexies	— Dexedrine (an amphetamine).
Dime Bag	— A bag of drugs worth ten dollars.
Down	— A drug hang over; also a barbiturate.
Dropping	— To take a drug by mouth.
Euphoria	— A feeling of well being induced by drugs.

Fed	An agent or policeman.
Fiend	A regular user of drugs.
Fix	An injection of drugs.
Flashback	A recurrance of a trip without drugs.
Flying	Being high on drugs.
Freakout	To lose contact with reality while on drugs.
Fruit Salad	A variety of drugs.
Garbage	Weak or heavily diluted drugs.
Goof Balls	Barbiturates.
Grass	Marijuana.
Habit	Addiction to drugs.
Hang Up	A personal problem.
Hard Stuff	A strong narcotic drug.
Hash	Hashish.
Head	A drug user.
Heat	The police.
High	Feeling you get while using drugs.
Hip	To be in the know.
Hooked	Physical addiction to drugs.
In	Being accepted.
Jones	Withdrawal symptoms.
Joint	A marijuana cigarette.
Joy Pop	To shoot heroin into a muscle.
Junk	Term used for heroin.
Junkie	One who uses hard drugs.
Kheef	A form of hashish.
Kick	To stop using drugs.
Kilo	2.2 pounds of any drug.
Lid	One ounce of marijuana.
MDA	An hallucinogenic amphetamine.
Mainline	To shoot drugs into a vein.
Man	A policeman.
Manicured	Marijuana without seeds or stems.
Marijuana	Pot, grass, weed.
Mescaline	The alkaloid of peyote.
Meth	Methedrine (Speed).
Mikes	Micrograms (unit of measurement).
Morphine	A form of Opium.
Narc	A narcotic law enforcer.
Needle	Hypodermic syringe.
Nickel Bag	A five dollar quantity of drugs.
Number	A marijuana cigarette.
Nod	The bowing of the head in a dream-like state.
O. D.	To overdose with a drug.
Off	To get high.
Orange Sunshine	A form of LSD.
Outfit	Equipment for injecting drugs.
PCP	Phencyclidine, an animal tranquilizer used as an hallucinogen.
Panama Red	A high grade of marijuana.
Pigs	Police.
Pot	Marijuana.
Pusher	A person who sells drugs.
Rainbows	Tuinal, a combination barbiturate.
Rap	to talk.
Reds	Seconal, a barbiturate.
Roach	The butt of a marijuana cigarette.
Roach Clip	A device used to hold the butt of a marijuana cigarette.
Roll	To make a marijuana cigarette.
Rush	A tingling and numbness that goes up the body.
Rip Off	To steal or swindle.
STP	An hallucinogenic amphetamine.
Score	To buy drugs.
Shoot	To inject drugs.
Skag	Heroin.
Smack	Heroin.
Smoke	Marijuana.
Snort	To take drugs by sniffing.
Spaced Out	In a daze.
Speed	Amphetamines.
Speed Ball	A mixture of cocaine and heroin or morphine.
Spike	A needle.
Stash	A hidden supply of drugs.
Stoned	Being high on drugs.
Strung Out	Addicted to drugs and suffering from side effects of the drug or withdrawal symptoms.
THC	The chemical in marijuana causing the high.
Tabs	Tablets or pills.
Toke	A drag off a marijuana cigarette.
Tracks	Marks left on the skin from repeated injections.
Trip	An experience resulting from use of an hallucinating drug.
Turn On	To use drugs.
Up	Being high on a drug.
Up Tight	Under stress.
Ups	Stimulants, usually amphetamines.
User	A person who uses drugs.
Vibes	Feelings coming from another or situation.
Wasted	Intoxicated on drugs.
Weed	Marijuana
White Lightening	A form of LSD.
Works	Equipment used to inject drugs.
Yellow Jackets	A short acting barbiturate (Nembutal).
Zapped	To be intoxicated on drugs.
Zig Zag	A brand name of cigarette paper used to roll marijuana cigarettes.
Zonked	To be intoxicated on drugs.

Name: ______________________

DATE: ______________________

Reading, Writing, and Reefer

Study Guide on Marijuana

1. A. What are some commonly used names for marijuana?

   B. What is the botanical name for the marijuana plant?

   C. Where does marijuana grow? What does it look and smell like?

   D. How is marijuana used?

2. A. How many chemicals are contained in marijuana plants?

   B. How many of these chemicals are found in no other plant?

3. A. What is the psychoactive or mind-altering ingredient in marijuana that has the ability to intoxicate its users and whose concentration in different parts of the plant determines the potency?

   B. What controls the THC content of the marijuana plant?

4. A. What has happened to the potency (THC content) of marijuana on the streets and in the schoolyards over the last few years?

   B. What has caused this?

C. What has happened simultaneously to the rate of use among kids?

5. A. How long does THC stay in the body?

B. Where does THC tend to accumulate?

C. Does the accumulation help explain why heavy smokers develop an apparent tolerance to marijuana?

6. How does marijuana affect the circulatory system?

7. How does marijuana affect the respiratory system?

8. Can marijuana cause cancer?

9. What does marijuana do to the brain?

10. A. What are the mental and emotional effects of marijuana?

B. How long does the high (total mental effects) of marijuana last?

11. How does marijuana affect the hormonal and reporductive systems?

A. Males-

B. Females-

C. Both Sexes-

12. A. Check all of the following that apply to what the actual interviews with and observations of chronic young pot smokers on the program revealed:

____ loss of goals/purposelessness

____ behavioral change

____ doesn't care about anyone or anything except getting high

____ personality change

____ disinterest in school and related activities

____ inability to recognize others who are burned out

____ inability to recognize burnt out in oneself

____ careless in physical appearance and social duties

____ impaired short term memory

____ eyes reddened

____ increased appetite, especially craving for sweets

____ loss of energy (sit around alot, slow moving)

____ change in school attendance

____ discipline problems

____ inattentive

____ mentally dull

____ hallucinations

____ family problems

____ decreased awareness and judgment

____ distortion of perception (esp. depth & time)

____ inability to concentrate, wandering mind

____ lack of motivation

____ enlarged pupils

____ lack of coordination

____ drowsy, hard to wake up in the morning, sleepiness, state of semi-sedation

____ dragged out, incomplete sentences

B. How does the marijuana user behave in the early stages of usage?

C. How do the kids interviewed describe being burned out (prolonged use)?

13. What happens if you drive after smoking marijuana?

14. A. What opinions are expressed by Keith Stroup, Director of NORML (National Organization for the Reform of Marijuana Laws)?

B. What's the difference between decriminalization and legalization?

C. What are the penalties for marijuana convictions?

15. What does Dr. Robert Dupont, former director of the National Institute for Drug Abuse, say about marijuana's health effects?

16. What are the additional dangers of "black market" or illegal drugs such as marijuana - besides the direct effect of the drug itself?

17. What are the potential possible social and economic consequences of increased marijuana use compared to alcohol and tobacco?

18. Are there any possible medical uses of the chemicals in marijuana?

19. List some clues which might indicate marijuana use?

ANSWERS TO READING, WRITING AND REEFER

1. A. What are some commonly used names for marijuana?
pot, grass, reefer, weed, maryjane, tea, joint, locoweed, hashish, gage, stuff, acapulco gold, a stick, goof butt, jive, sweet lucy, bhang, ganja, stinkweed

B. What is the botanical name for the marijuana plant?
Cannabis sativa

C. Where does marijuana grow? What does it look and smell like?
Weed which will grow anywhere, wild and cultivated in many parts of the world.
Plant-belongs to hemp family - can grow to 12-14 ft. - almost anywhere any climate, any soil conditions, but prefers semi-tropic areas.
Smoking marijuana - usually looks like greenish tobacco-often contains seeds and stems. Usually hand-rolled with paper heavier than tobacco cigarettes and closed at both ends because of loose fill and dryness of the weed --shorter than normal cigarette length.
Burning odor-burning rope or alfalfa.

D. How is marijuana used?
Smoked in cigarette or pipe .
Other tobacco is mixed with it to act as a binder and make it burn more slowly. "Steamboating" - smoked through a cardboard from roll of toilet paper.
Extract and separate resins and take orally with tea or mixed in a cookie or brownie. (May extract by boiling the plant).
Eaten produces delayed effect-loggy in A.M., nightmares, paranoia, confusion, anxiety. Often eat more because no immediate effect.

2. A. How many chemicals are contained in marijuana plants?
Over 300 - now estimate 350-400

B. How many of these chemicals are found in no other plant?
60

3. A. What is the psychoactive or mind-altering ingredient in marijuana that has the ability to intoxicate its users and whose concentration in different parts of the plant determines the potency?
Delta-9-tetrahydrocannabinol or THC.
THC-obtained from the amber colored resin of the flowering tops and leaves of the female plant.
Really an hallucinogen possessing ability to stimulate and depress.
In order to affect brain, liver must change it to 11-hydroxy-THC.

B. What controls the THC content of the marijuana plant?
Plant strain, climate, soil conditions and time of harvesting.

4. A. What has happened to the potency (THC content) of marijuana on the streets and in the schoolyards over the last few years?
It has increased significantly. 1975-average confiscated sample of marijuana 0.4% THC
Typical joint-dried particles or whole plant except main stem & roots. 1979-up to 4% - 10 fold increase
Hashish (Hash)-green dark brown or black resis-in past average THC content 2%.
Hash oil-up to 30% THC content (tar-like substance, usually smoked in small amounts on tobacco or marijuana or in small glass pipes).
Sinsemmilla-a cultivated form becoming more common in U.S. may contain 7% THC.

B. What has caused this? Selective cultivation.

C. What has happened simultaneously to the rate of use among kids?
1978-seniors - 11% daily or near daily
1975-seniors - 6% daily or near daily
Nearly doubled in 3 yrs. Dr. Lloyd Johnston; Institute for Social Research-University of Michigan.
1978-Gallop Poll - 81% high school students said it was easy or fairly easy to get. 60% of junior high students said same thing.

5. A. How long does THC stay in the body?
Up to 3 days after smoking ½ or 50% still there. Exactly how long it takes the last traces of THC to leave the body and the precise mechanisms by which this occurs remains a secret. Studies have found THC metabolites in blood and urine up to a week after it is ingested. In tests involving radioactive THC-have found them up to a month.

B. Where does THC tend to accumulate?
In the brain, fatty tissue around the reproductive or sex glands and in other vital organs.

C. Does the accumulation help explain why heavy smokers develop an apparent tolerance to marijuana?
Yes, heavy smokers have to smoke more or stronger pot in order to feel high.

6. A. How does marijuana affect the circulatory system?

1. Heart increases rate as much as 50% - chest pains, especially in people who are experiencing a poor blood supply to the heart. Therefore people with heart conditions are a high risk and should under no circumstances use marijuana.

2. Long term use decreases rate, produces heart murmurs and arrhythmias. B/P - not great deal of effect.

3. Mild decrease in body temperature.

7. A. How does marijuana affect the respiratory system?
Causes dryness of mouth and throat.

Users tend to inhale unfiltered smoke deeply and hold it as long as possible keeping the smoke in contact with lung tissue for prolonged periods. Repeated inhalations (whether tobacco or marijuana) inflames the lungs and affects pulmonary functions.

Physicians are finding 40-45 yr. old lungs in teenage chronic potheads. National Institute on Drug abuse 1978. Studies comparing harm of marijuana

7. and tobacco have shown that chronic marijuana use (5 J's/wk for several yrs.) is more irritating to air passages and impairs or decreases the lungs ability to exhale air than chronic tobacco smoking almost 6 packs of cigarettes/wk (over 5 packs - 16 or more cigarettes/day). 5 J's = 112 tobacco cigarettes in terms of effect. Dr. Donald P. Tashkin-one joint equals the same inflammation as over a pack of regular cigarettes. Equivalent to Camels during WWII in carcinogens.

8. Can marijuana cause cancer?
Condensed marijuana smoke has higher percentage of carcinogens than tobacco cigarette of some size. Biopsies of chronic marijuana smokers lung tissue showed cellular changes called metaplasia (precancerous condition). In lab tests, tars from marijuana smoke have produced tumors when applied to animal's skin.
(1978 National Institute on Drug Abuse). Today's teens are a generation of guinea pigs.

9. What does marijuana do to the brain?
Rhesus monkeys - 1 J for 5 days/wk. for 6 months resulted in persistent changes in the structure of the monkeys brain cells. Therefore, researchers have concluded the possibility of subtle and lasting changes in brain function from heavy and continuous marijuana use.
In **humans**, there is evidence of sleep disturbances - less dreaming sleep and sleep brain wave changes are dramatic. Small amounts release inhibitions.

10. A. What are the mental and emotional effects of marijuana?
Dr. Sidney Cohen, UCLA School of Medicine, says it alters the thought processes.

- suspect some mental impairment which is not reversible.
- those who continue smoking good stuff over # of yrs., may becom so impaired that they will never function at their best level of effectiveness.
- interferes with move to psychological adulthood. Impairs learning by impairing thinking, reading comprehension, and verbal and arithmetic skills.
- often makes depression or other emotional disturbances worse. Does not directly cause mental problems, but tends to bring to surface emotional problems and even trigger more severe disorders like schizophrenia.

Most common adverse reaction is the acute panic-anxiety reactions (state of anxiety sometimes with paranoid thoughts ranging from general suspicion to fear of losing control and going crazy). Acute anxiety reactions are usually experienced by novice users and symptoms are usually gone in a few hours. Over 10,000 emergency room visits related to marijuana in 1978. An estimated 5,000 per month seek professional treatment for problems related to marijuana.

Acute brain syndrome - involves clouding of mental processes, confusion, marked memory impairment related to strength of dose and diminishes as toxic (poisonous) effects wear off.

Marijuana flashbacks - occassional spontaneous recurrence of feelings and perceptions similar to those produced by the drug.

10. A. cont. Cannabis psychosis - occurs infrequently and involves bizzarre behavior and panic.

B. How long does the high (total mental effects) of marijuana last? 3-5 hours-occasionally up to 10 hrs.

11. How does marijuana affect the hormonal and reporductive systems?

A. Males - decreased testosterone level (principal male sex hormone) causing increase in appearance of female traits.
- decreased sperm count as marijuana use increases. Chronic use defective, abnormal and nonfunctional sperm. Means possibility of genetic damage to offspring.
- decreased pituitary growth hormone. All this makes it particularly harmful during the adolescent period of rapid physical and sexual development.

B. Females - research on pregnant women not permitted (possible reproductive risks). Defective menstrual cycles - 3 times more often than non-users. Failure to ovulate or shortened period of fertility - decrease fertility in women-decreased breast development.

Animals - decreased estrogen (principle female sex hormone) and progesterone (another hormone during 2nd part of cycle and decreased pituitary growth hormone.

Monkeys - 4 times more likely to abort or have stillborns. Male offspring are lighter than usual birth weight, hyperactive and unable to learn simple tasks as well.

C. Both Sexes - Decreases growth hormone in pituitary.

Decreases sexual desire (so gradual users don't notice difference). When quit-subjects report spectacular changes when sexual capacity returns when they hadn't realized it had slowed down, but they must abstain for 1 month.

12. A. Check all of the following that apply to what the actual interviews with and observations of chronic young pot smokers on the program revealed:
All apply.

B. How does the marijuana user behave in the early stages of usage? Overall effect predicted largely by user's personality and presence of others in room having similar sensations. Difficult to recognize unless actually under the influence and even then may be able to work reasonably well. Person may appear relaxed, animated with rapid, loud talking and outbursts of laughter and talkativeness.

12. C. How do the kids interviewed describe being burned out (prolonged use)?
Drastic change in way it makes you feel. Sick of the high.
Don't get high. Don't like to do much - feel lazy - act "dumb" - don't pay attention to those talking to you. Not as keen or sharp mentally, but this is not perceived by the person himself.

13. What happens if you drive after smoking marijuana?
Slows reflexes to sights and sounds. Delays responses (increased reaction time just like alcohol) - takes driver longer to react to dangerous situations. Causes visual distortions. Ability to perform sequential tasks, especially in the face of unexpected events, is impaired. Greater the demands of a driving situation, the less able the user is to cope. Driver who doesn't feel high may still be under the influence as effects last several hours after high passes. Reduces ability to perform tasks requiring concentration, swift reactions and coordination.
Effects persist several hours beyond the time the person "feels high".
So user may drive without realizing s/he's still impaired.
Color perception is altered or impaired.
Ability to detect a moving object is reduced. Less awareness of visual stimuli (things happening on the edge of vision.) Takes longer to make decision.
Tests at Southern California Research Institute-severely impairs driver's perception, concentration, reaction time and overall driving skill.
Decrease in driving ability is directly related to the amount of marijuana smoked.

14. A. What opinions are expressed by Keith Stroup, Director of NORML (National Organization for the Reform of Marijuana Laws)?
"There is a tendency on the part of young people today to underestimate the potential for harm from psychoactive drug use. I would caution them against this. There is no such thing as a totally safe drug, and I don't think marijuana is going to be the first. It should obviously not be something people do before they study for exams or things like that."

Keep in mind these are the words of the head of an organization crusading for reform of marijuana laws.

After 5-10 minutes, users feel restlessness and anxiety. Speech becomes rapid, time passes slowly, distances may appear shortened, memory deteriorates and coordination becomes difficult.

B. What's the difference between descriminalization and legalization?
Decriminalization reduces penalty for possession of small amounts. Large amounts (over 1 oz.) is a felony in all states. Law is harsh for dealers. Does not imply it is okay to use or safe that legalization would imply. However, 999 out of 1,000 think decriminalization is symbolic of support for marijuana.

C. What are the penalties for marijuana convictions?
Misdemeanor - any amount.
Probation - 1 year for less than 1 oz.
Class D Felony - any amount of a substance containing marijuana with intent to sell. (Sale includes giving.) ¼ oz. or more, or 25 cigs. or more of a substance containing marijuana. Probation for 1-7 yrs.
Class C Felony - 1 oz. or more, or 100 cigs. or more of a substance containing marijuana. Probation for fist offense - 1-15 yrs.

15. What does Dr. Robert Dupont, former director of the National Institute for Drug Abuse, say about marijuana's health effects?
"Disaster in terms of health consequences." More harmful than tobacco or alcohol for several reasons:
1. We know a lot more about health hazards now.
2. Because people have interpretted its comparison to alcohol and tobacco as a meaning it's OK. People assume it's not worse, but look at the mess we're in with the others.
3. Intoxication, which clouds distinctions, makes it dangerous to drive.
4. Juveniles who smoke it are in legal sense a "generation of outlaws on receiving end of a vast criminal network of growers, smugglers and distributors.
5. Chemicals are there that are known to cause cancer and we need to let people know this.

16. What are the additional dangers of "black market" or illegal drugs such as marijuana - besides the direct effect of the drug itself?
Potency is unknown. May contain hazardous impurities. Antihistamines, Speed, DMT, Opium, Formaldehyde, Insecticides.

PCP-phencyclidine (Angel Dust) - large animal tranquilizer - which is addictive. (1/4 - 1/2 of drugs bought are not what they're sold as).

1% of kids who never use marijuana went on to use other drugs.
26% of kids who did use marijuana went on to use other drugs.
Paraquat-herbicide, defoliant sprayed on Mexican pot in unsuccessful attempt by the government to control marijuana.

17. What are the potential possible social and economic consequences of increased marijuana use compared to alcohol and tobacco?
Since 1900 - every segment of population has become healthier, but 15-20 year olds - 15% increase in death rate.
30% of U.S. deaths are premature due to use of alcohol and tobacco.
U.S. spends $75 billion/yr. on costs of illnesses and health consequences:
    $30 billion/yr. due to tobacco smoking
    $45 billion/yr. due to alcohol related auto accidents, absenteeism and other consequences
Recent study of 300 drivers responsible for fatal accidents in Boston - according to interviews with witnesses: 39% intoxicated with alcohol and 16% with marijuana. 50% intoxicated with alcohol is national average.
Takes average of 20 years to produce clinical signs of cancer from tobacco use. Marijuana - more tar and more carcinogens. (We should start seeing cancer at younger and younger ages in pot smokers.)
We're about the only contry that's shown a willingness to consider marijuana as a legal drug. International treaties clearly prohibit its legalization. India, Egypt, Moracco - illegal for social reasons as it takes people out of mainstream of society.
14-25 only age group that shows any support of marijuana.
Arab World, Russian Bloc and most European nations oppose, except Holland which has become drug center for Europe.

18. Are there any possible medical uses of the chemical in marijuana?

A. Open-Angle Glaucoma - often leads to blindness due to increased pressure within eye. THC eye drops sometimes reduce pressure, but tolerance (need to increase doses to get same effects) develops and ultimately it has little or no effect. Does not prevent glaucoma or any other eye disorder or improve vision.

B. Nausea and vomiting associated with chemotherapy used in treatment of cancer patients. Does not prevent cancer and actually contains more cancer causing agents than tobacco smoke.

C. Multiple Sclerosis - some reports of decreased spasticity or involuntary muscle contractions.

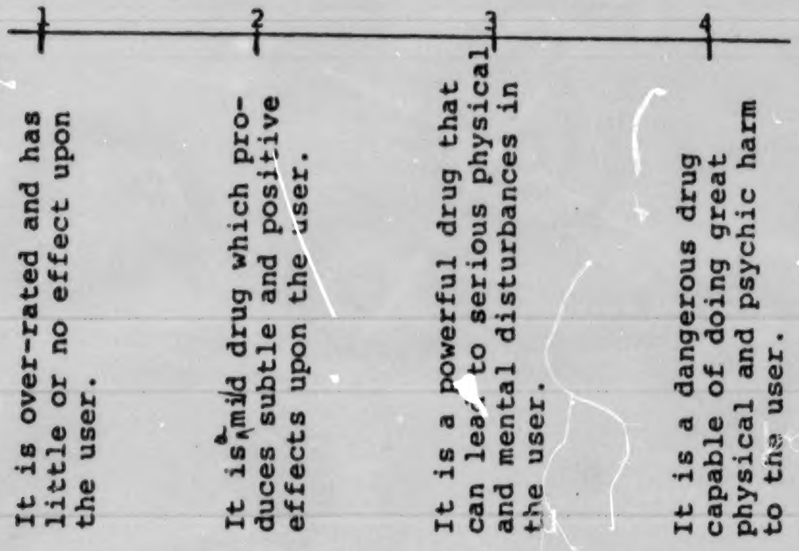
D. Epilepsy - THC may actually trigger seizures as it may stimulate high voltage brain waves, especially as dose increases. Another ingredient (cannabidiol) has shown in limited studies to decrease or control seizures. However this ingredient is found in only one strain of marijuana and this particular fiber strain contains little of the mind altering THC. This means street marijuana contains only trace amounts of it. It can be man made.

19. List some clues which might indicate marijuana use.
Associations with other known drug users
Strong odor of burnt leaves (rope) or alfalfa in air or on clothing or breath
Go to school or classes late or not at all
Small seeds in pocket linings
Finding paraphenalia-pipes (often wooden or ceramic), bongs
Cigarette rolling papers (Zig-Zag)
"Sinus" headaches
Discolored fingers
Chest pains
Sores on lips (from burns)
Roaches (remants of joints saved and used to help make a new marijuana cigarette)
Use of sunglasses at inappropriate times (indoors or at night) to hide dilated pupils or red eyes
Appears intoxicated, but no odor of alcohol on breath.
Reddened eyes, dilated pupils, drowsy, hard to wake up in morning
Starts keeping peculiar hours
Grades go down
Moody
Unable to account for where his/her money goes
Visits "head" shops
Frequent sore throats or clearing of throat
Increase in bronchitis, asthma attacks

REPORT CARD FOR THE TEACHER SHEET

HO-14

1. Circle one of the numbers of the positions on the continuum below which best characterizes your belief about marijuana.



1 It is over-rated and has little or no effect upon the user.

2 It is a mild drug which produces subtle and positive effects upon the user.

3 It is a powerful drug that can lead to serious physical and mental disturbances in the user.

4 It is a dangerous drug capable of doing great physical and psychic harm to the user.

2. Shade in the thermometer below to the appropriate level to indicate how much you learned tonight.

Meaning of Thermomenter Reading

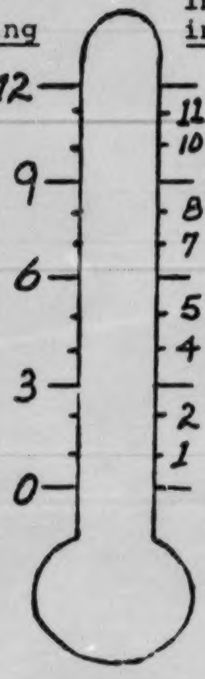
I learned a great deal I never knew before.

I learned quite a bit I didn't know before.

I learned some new infomation.

I learned just a very few new ideas.

I learned absolutely nothing new.



In this column, you may write in your own meanings if you prefer.

3. Do you have any unanswered questions about marijuana? (Please be specific)

4. Do you think that sessions such as we held tonight are an effective part of a school/community drug education program?

5. What did you like most about tonight's program?

6. What did you like least about tonight's program?

7. How would you improve it?

"SELF TEST ON READING, WRITING, REEFER"

HO-15

Directions: Place "T" for true and "F" for false in the spaces as directed by your instructor.

Pre-Viewing Answer		Post-Viewing Answer
____	1. Medical research on marijuana smoking has been done on both youth and adults.	____ 1.
____	2. Most parents are aware of the extent and the rapid increases in the use of marijuana.	____ 2.
____	3. The use of other illicit drugs has not grown along with the use of marijuana.	____ 3.
____	4. The peddling of the paraphernalia of marijuana is a billion dollar industry.	____ 4.
____	5. The potency of marijuana in our streets and schoolyards has remained constant over the past decade.	____ 5.
____	6. No one with a heart condition should use marijuana.	____ 6.
____	7. There is no such thing as a totally safe drug.	____ 7.
____	8. Chronic use of marijuana is more of a hazard to health than chronic use of tobacco.	____ 8.
____	9. Marijuana cultivation is legal in Colombia.	____ 9.
____	10. Since one of the effects of marijuana is to slow things down, it is a fact that driving while stoned is O.K.	____ 10.

________ Pre-Viewing Score

________ Post-Viewing Score

"SELF TEST ON READING, WRITING, REEFER"

HO-16

Directions: Place "T" for true and "F" for false in the spaces as directed by your instructor.

Pre-Viewing Answer		Post-Viewing Answer
F	1. Medical research on marijuana smoking has been done on both youth and adults.	F 1.
F	2. Most parents are aware of the extent and the rapid increases in the use of marijuana.	F 2.
T	3. The use of other illicit drugs has not grown along with the use of marijuana.	T 3.
T	4. The peddling of the paraphernalia of marijuana is a billion dollar industry.	T 4.
F	5. The potency of marijuana in our streets and schoolyards has remained constant over the past decade.	F 5.
T	6. No one with a heart condition should use marijuana.	T 6.
T	7. There is no such thing as a totally safe drug.	T 7.
T	8. Chronic use of marijuana is more of a hazard to health than chronic use of tobacco.	T 8.
F	9. Marijuana cultivation is legal in Colombia.	F 9.
F	10. Since one of the effects of marijuana is to slow things down, it is a fact that driving while stoned is O.K.	F 10.

______ Pre-Viewing Score

______ Post-Viewing Score

HO-19

State of New York
COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION
Office of Alcoholism and Substance Abuse

Alcohol and Substance Abuse Fact Sheet Series

MARIJUANA

MARIJUANA: SOME BRIEF FACTS

There are many facts to remember about marijuana. The first one, of course, is that it is illegal. In some states, just possessing it carries a jail sentence or heavy fine. In New York State, small amounts for personal use carry a small fine, while larger amounts (or any amount for sale) make the person involved liable for a jail sentence, a large fine, or both. The present laws are listed on the reverse side.

One of the important things about marijuana being illegal is that if you use it (or any other drug) in your parents' house, this means that they are also guilty under the law, and can be arrested, fined, or both.

Most people realize that this is an illegal drug, but there are many questions as well that people often ask about this controversial weed. Let's look at some of them:

Marijuana starts out as a plant which is grown in many parts of the world. It can be potent enough to get several people high on only one joint, or it can be so weak that smoking a whole sack of the dried leaves can only give someone a headache. This depends on where and how it is grown, and other factors.

Hashish is a more potent form of marijuana, a concentrate made from the resin of the plant. But in either form it is not physically addicting. There is no withdrawal even if larger amounts are smoked, and suddenly stopped. Marijuana does not make the user "crave" hard drugs such as heroin. This is a myth that many people still believe.

Many people believe that marijuana is the number one drug problem. This is because much false or unproven information has come out about this drug in the past. People were told that it was addicting, and caused such things as insanity and permanent damage to the body. All this has proven to be scientifically incorrect.

There are many other myths about this drug. Thousands of pages have been devoted to study of this drug by one federal subcommittee alone, and the results have been written up in a report called "Marihuana: A Signal of Misunderstanding." The conclusion is that marijuana is the second most frequently used drug in America, besides alcohol, and that most of the scare stories about it in the past have been proven false.

There are certain things wrong with it, of course. Marijuana smoke is hot and harsh if burned in joints or short pipes, and can damage lungs at least temporarily. (This is why so many people who smoke it use water pipes and other pipes which cool the smoke.) Marijuana, like other drugs, does not make you smart, but can alter one's state of mind to make anything appear possible. It is usually classified as a mild hallucinogen, but its effects can also be like a downer or, occasionally, a mild stimulant.

Marijuana smoke is also carcinogenic, and is probably as harmful as cigarette smoke, if not harsher. (Exactly how harsh is a matter of scientific debate currently.) However, cigarette smokers usually smoke at least one pack of 20 a day. Marijuana smokers use between one and three joints a day, if they are regular users, and between three and five a day, if they are heavy users, by most government standards. So developing lung cancer after many years is not a likely threat, at least from what we know today. Of course, smoking marijuana and also having a cigarette habit can be more dangerous to health. Tobacco is, of course, the cause of many deaths by lung cancer, emphysema, heart disease, and so on, as well as chronic conditions like bronchitis. Marijuana is also bad for anyone already suffering from any of these problems.

Sometimes people bake this drug into things which are edible, such as cookies or brownies. Few people have bad reactions to smoking marijuana (some people are allergic to it, as they quickly find out). But when marijuana is eaten, many more people have bad reactions. It is hard to control the length of the high when it is eaten, and can cause headaches, nausea, or a type of reaction the whole next day that is not at all pleasant.

Some people who use needles have tried to boil up marijuana, then shoot up (inject) the resin. This causes nausea, convulsions and vomiting for up to two days afterwards, and is so bad that no one has ever wanted to do it again, according to hospital records.

Marijuana does not cause any type of permanent damage that we know of at this time. But of course we still do not know everything about this, or almost any other drug used for intoxicating purposes.

So why do some people think marijuana is so terrible?

Possibly the biggest reason is because this drug still represents "rebellion" and going against society. It really was such a symbol in the past. When some adults think about marijuana, they think about hippies in the 1960's, runaways, and all sorts of bad things. When other adults think about marijuana, they see it as a weed that can be good or bad, depending on how it is used. There are all sorts of opinions, and many arguments on this subject.

For one reason or another, marijuana is a hard subject for many parents and children to discuss. It is also hard for some teachers as well. Those who are against marijuana often believe it is the worst drug in the world. Those who like it may feel just the opposite way.

On the other hand, marijuana will not make you more intelligent or more popular. It just gets you stoned, and that is all. It can get to be a bad thing you sit around and do nothing else with your e except smoke it and be high all the time. Or it n be a bad thing if you get loaded and try to do mething complicated, or run dangerous machinery, drive or ride a bicycle down a busy road.

But marijuana can also be a good drug in ating certain diseases, such as glaucoma (an eye sease). Marijuana may also be prescribed someday rough the drug store for certain medical problems, it not **now**. Some states have made it legal for aucoma **so** far, but supplies must be obtained der a special government license.

Statistically, between 50 and 60 million people the United States have tried this drug, and between 2 and 15 million are said to be regular users, by me estimates. It is technically illegal in almost ery country in the world, but in some countries ce India, Pakistan, Afghanistan and others, use f hashish and marijuana has gone on for centuries, uch like alcohol has been used in Europe and merica, as a social drug. In every country where is used, one rule holds true: It can be a harmful drug if it is used too much by people who would rather stay high than solve their problems and make a better life for themselves and their families.

THC, as many people know, stands for Delta 9 Tetrahydrocannabinol, the principal active ingredient in marijuana. But when most people buy what they think is THC, it turns out to be PCP (phencyclidine), an anesthetic that has been used as an animal tranquilizer. This is a dangerous drug that can cause memory failures (blackouts) and fatal accidents. Possibly millions of people are fooled every year by this ripoff. Real THC (synthetic marijuana) costs as much as $50 a dose to manufacture, and is never sold by street dealers. For more information, see the PCP fact sheets also produced by CASAPE.

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MARIJUANA REFORM ACT OF 1977

POSSESSION	SALE*	CLASSIFICATION	PENALTY
Up to 25 grams* - Second offense - Third offense	- - -	Violation	Up to $100 fine Up to $200 fine Up to $250 fine and/or 1[illegible] days jail
Over 25 grams or any public use	Up to 2 grams or 1 cigarette	Class B Misdemeanor	Up to 3 months jail or $500 fine
Over 2 ounces	Up to 25 grams	Class A Misdemeanor	Up to 1 year jail or $1000 fine
Over 8 ounces	Over 25 grams	Class E Felony	Up to 4 years prison
Over 16 ounces	Over 4 ounces or any amount to a minor**	Class D Felony	Up to 7 years prison
Over 10 pounds	Over 16 ounces	Class C Felony	Up to 15 years prison

*25 grams = about ⅞ of an ounce
**A minor is anyone under 18 years of age

*Sale of marijuana includes giving the drug to someone as a gift or passing a marijuana cigarette to another person. A public place is defined as any place where the public or a substantial group of persons can go. This includes: streets, buses, planes, trains, schools, parks, hallways and lobbies of buildings and places of amusement.

New York State Division of Substance Abuse Services

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE

HO-20

MARIJUANA: SOME BRIEF FACTS

COMPLIMENTS OF
TARKY LOMBARDI, JR.
SENATOR 50th DISTRICT

WHAT IS MARIJUANA?

Marijuana ("grass," "pot" "weed") is a common plant with the biological name of Cannibas sativa. The psychoactive ingredient in marijuana is delta-9-tetra hydrocannabinol, or THC. The flowering tops of the plant contain the highest THC concentration.

Hashish or "hash" is a dark brown resin from the tops of Cannabis sativa. It is usually much stronger than crude marijuana since it typically contains 5 to 10 times more THC. "Hash oil" is a distillate of the marijuana plant with a concentrate of THC of 5 40 percent or even higher. The effect on the user is more intense and the possibility of side effects is greater.

DOES MARIJUANA VARY IN STRENGTH?

Yes. Some marijuana may produce no effect at all, while a small amount of strong marijuana (hash) can produce a marked reaction in some persons. The THC content of the marijuana plant usually determines its psychoactive potential, but the ultimate effect is the interaction between the user and the drug. Plant strain, climate, soil conditions, time of harvesting, and other factors determine the strength of marijuana The plant that grows wild in the United States is usually lower in THC than cultivated marijuana, especially Mexican, Lebanese, Southeast Asian, or Indian varieties. Because the strength and chemical composition of naturally grown marijuana vary so much, Delta-9-THC is synthesized (created through a chemical process) so that a pure, measurable drug is available for drug abuse research.

HAVE MANY PEOPLE TRIED MARIJUANA?

An estimated 41-47 million Americans have tried marijuana at least once; approximately 16-20 million were considered current users at the time of the last national survey (1976). Adolescents and young adults (18-25 years old) make up the largest percentage of these users. Younger teenagers (12-17) and older adults (26 and above) have significantly lower use rates.

WHAT ARE SOME OF THE IMMEDIATE EFFECTS OF SMOKING MARIJUANA?

Most users who smoke marijuana experience an increase in heart and pulse rate, reddening of the eyes, and dryness in the mouth and throat. Many feel that their hearing, vision and skin sensitivity are enhansed by the drug, although these reports have not been objectively confirmed by research. Feelings of euphoria, relaxation, altered sense of identity, and bouts of exagerated laughter are also commonly reported at social dose level of marijuana. Some of marijuana,s mental effects include impaired memory and an altered sense of time. In addition, decreases in performance on a number of tasks involving reaction time, learning, perceptual-motor coordination, and attention are reported.

DO PEOPLE EVER REACT BADLY TO THE DRUG?

The most commonly reported adverse reaction to marijuana use is the "acute panic anxiety reaction", usually experience by novice users after smoking strong marijuana. It is usually described as an exaggeration of normal marijuana effects in which fears of losing control and going crazy produce severe anxiety. The symptoms usually disappear in a few hours when the drug effects wear off.

CAN MARIJUANA CAUSE DEPENDENCE?

Tolerance to cannabis has been verified by research. But dependence on marijuana with demonstrated withdrawal symptoms has only been shown in research experiments which used high doses of THC. These doses are not typical of marijuana use in the United States.

IF IT DOESN'T CAUSE DEPENDENCE, WHAT'S THE PROBLEM?

The real danger in marijuana use, as in all serious drug use by young people, is that drug taking interferes with the normal process of growing up. Young need to learn how to make decisions to deal with sucess and failure, and to form their own beliefs and values to carry with them into adulthood. Drug taking can be an escape from these "growing pains" and may mean that the young person will never learn these important skills of maturity, independence, and responsibility.

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DOES MARIJUANA HAVE ANY MEDICAL USES?

Marijuana has been used in the folk medicine of many countries since ancient times. Its reputation as a therapeutic drug has led to research on its value in the treatment of glaucoma and asthma. In addition, it is being tried to reduce the nausea and vomiting experienced by cancer patients undergoing drug therapy. These preliminary investigations are only the first steps in a very long process of establishing the safety and therapeutic value of the drug.

DOES MARIJUANA AFFECT CHROMOSOMES, AND IS IT LIKELY TO HAVE EFFECTS ON CHILDREN OF USERS?

This is still an unanswered question. While some researchers believe they have found chromosonal abnormalities in blood cells of heavy users, other equally qualified scientists have not. Technical difficulties in the research and the exact significance of possible abnormalities make it difficult to develop any general conclusions at this time. This work is being continued, and findings are being made public as they become available.

WHAT EFFECT DOES MARIJUANA USE HAVE ON THE BODY'S RESISTANCE TO DISEASE?

Some recent research has suggested that marijuana may reduce a person's resistance to disease by interfering with the body's immune response. Other studies have shown no reduced immune response in users. Research is still underway.

HOW DOES MARIJUANA AFFECT DRIVING?

Research has shown that social doses of marijuana can impair driving ability. Actual driving experiments reveal that the drug has a significant effect on judgement, care while driving and concentration. Marijuana also affects the driver's perceptual and motor abilities. A recent study of 300 drivers responsible for fatal accidents in Boston showed that 39 percent were intoxicated with alcohol and 16 percent were under the influence of marijuana at the time of the fatal crash, according to interviews with witnesses. Even with the current, somewhat limited, use levels of the drug among the population, marijuana use presents a definate danger on the road.

IS THERE ANYTHING IN MARIJUANA ITSELF THAT LEADS TO THE USE OF OTHER DRUGS?

There is nothing in marijuana that produces a need for use of other drugs. The overwhelming majority of marijuana smokers do not progress to so called stronger drugs, but some users do. Surveys show that regular users are more likely to experiment with other drugs such as hashish, hallucinogens, amphetamines, and occasionally, barbiturates and heroin.

IS MARIJUANA LESS HARMFUL THAN ALCOHOL?

The effects of either drug can be harmful. We know that alcohol is a dangerous drug physically, psychologically, and socially for millions of people. There is not enough information or experience to estimate the adverse effects of marijuana if it were to be used on the same scale as alcohol.

IF ALCOHOL AND TOBACCO ARE LEGAL WHY NOT MARIJUANA?

To legalize marijuana based on our experience with tobacco and alcohol would be to ignore the very real problems we face today with these two legal drugs. Once a drug becomes an accepted part of society, it is very difficult to end its use even when very serious health hazards are associated with it. The long term effects of marijuana use are not yet known. Like tobacco, it may take 50 years to discover some of marijuana's most serious consequances. Many feel that it makes sense to wait for the results of careful research before treating marijuana in the same way as alcohol or tobacco.

WHAT IS MEANT BY DECRIMINALIZATION?

Decriminalization refers to the legal process of revising the marijuana laws by replacing the criminal penalities (usually imprisionment or the threat of imprisionment) with civil penalities (most often a fine) for possession of small amounts of the drug for personal use. Most people feel that marijuana use should be discouraged, but many also feel that imprisionment for use is too harsh a penality Ten States have already changed their laws to incorporate civil fines and, sometimes mandatory drug education programs for offenders. First offenders usually avoid a criminal record under these new laws.

WHAT RESEARCH IS BEING DONE ON MARIJUANA?

Some of the research currently being done is to:

1. Evaluate long-term effects of marijuana use among large populations of American users;
2. Determine the effect of marijuana use by adolescents on the development of life skills and values
3. Study the effect of decriminalization of marijuana use in the 10 States where the law has been changed;
4. Determine the effects of marijuana on physical and mental skills;
5. Investigate in greater detail the chemical properties of marijuana, its effects on the body and the behavior of animals and humans; this includes possible genetic damage and effects on the body's resistance to disease; and explore the therapeutic uses of marijuana for use in cancer chemotherapy, glaucoma, asthma, and other diseases.

ALCOHOL USE AND ABUSE

I. What is alcohol?

  A. Drug - useful under care of a doctor for treatment of certain conditions.
  B. Poison - especially when an excess is consumed - upsets normal body functions often to the point of serious body injury.
  C. Fuel - does burn
  D. Used in solutions as in -
    1. Medicines
    2. Auto radiator anti-freeze
    3. Antiseptics - used by doctors, druggists, etc. to kill germs or bacteria outside the body.

II. Types of alcohol

  A. Ethyl alcohol - grain alcohol - C_2H_5OH
    1. Used in beverages
    2. Produced by the action of yeast (a tiny plant) on carbohydrates (sugars). Fermentation of grain or fruit juices. Mash made from ground corn, rye, barley, wheat, or other cereals is used to make it.
    3. Colorless, inflammable liquid with a pungent odor and a burning taste.
    4. Types of ethyl alcohol or basic alcoholic beverages:
      a. Beer and ale
        1. 2-5% alcohol content
        2. Made by the action of yeast on mash containing ground grain and malt - fermentation of grain.
      b. Wines
        1. 10-20% alcohol content
        2. Produced by the action of yeast on fruit juices - especially fermentation of grapes.
      c. Spirits - whiskey, brandy, gin, rum and other liquors.
        1. 30-55% alcohol content
        2. Produced by distilling fermented grains, molasses, or fruit juices to increase the alcohol content.

  B. Methyl alcohol - wood alcohol - CH_3OH
    1. Made from the distillation of wood in the absence of air.
    2. Very poisonous - even its fumes are dangerous.
    3. Produces gastric irritation or disturbance, blindness or death.
    4. Used commercially in the manufacture of varnishes, shellac and dyes.

  C. Denatured alcohol
    1. Ethyl alcohol with substances added to it making it poisonous if taken interanlly.
    2. Used largely for industrial purposes.

D. There are many other alcohols and related substances such as ether (which is made from alcohol) and glycerin.

E. Proof - alcohol content of distilled liquors.
To test the content of whiskey, people would put it on gunpowder. If there was little water present and over 50% alcohol, the mixture would explode when lit. This was "proof" of the volume of alcohol - 100 proof.

There fore: 50% alcohol = 100 proof
40% alcohol = 80 proof

III. Effects on the body

A. Depressant - flash of energy and then its gone. It decreases body activities and deadens nerves. For this reason, the person thinks it is a stimulant because he no longer worries so much about how he's getting along and feels sharper and thinks he can think more clearly.

B. Effects on the body depend largely on the amount of alcohol the drink contains and how quickly it was consumed and the size of the person consuming it.

C. Within 2-5 minutes after drinking, alcohol begins to leave the stomach and enter the blood.

D. Because alcohol is not digested, the blood receives it immediately since it is absorbed without any change having taken place.

E. The rate of absorption increases as the alcohol enters the small intestine (duodenum) right after the lower end of the stomach.

1. When mixed with food, the rate of absorption is decreased.
2. Therefore, when a person drinks on an empty stomach rather than during or after a meal, he feels the effects much more drastically and quickly.

F. Once the alcohol is absorbed, it is taken by the blood to the brain, liver, muscles, and other body tissues where it is absorbed into the water the tissue contains in proportion to the amount of water in that particular tissue.

G. Oxidation - body tissues normally burn part of the foods one eats by adding oxygen to them (Fire is rapid oxidation).

1. Energy and heat are released.
2. Much of the energy from food is used to keep tissues alive.
3. The speed of oxidation depends on the energy one needs.
4. The body burns up about 98% of the alcohol without control to produce heat and more heat which the body doesn't need. (This energy in the form of extra heat does not contribute to life---the problem is to get rid of it!)

5. The blood picks up heat in the tissues and carries it to the skin which turns pink (flushes) with its extra blood supply and heat pours from the skin surface by radiation.

  a. Nerves in the skin send forth the impression or sensation of body warmth, but this warmth is all on the surface (capillaries in the skin enlarge and give off the excess heat). This is a false feeling of warmth.

  b. Alcohol slows nerve action which keeps the walls of the surface blood vessels slightly dilated resulting in relaxation and increased blood flow to the skin. Body temperature actually decreases.

H. The average adult can use only 1/3 to 1 ounce or about 3 teaspoons per hour. (1 tablespoon = 1/2 ounce = 3 teaspoons = 1 tablespoon). Up to 1 ounce of 100 proof (50%) whiskey can be oxidized per hour. At this rate, it would take nearly 24 hours to use up the alcohol in one pint of whiskey.

I. The amount and kind of alcohol is the same in a "shot" of whiskey, a glass of wine, and a 12-ounce bottle of beer.

J. Generally, the smaller the body, the greater the effect.

K. High correlation between alcohol, suicide and cancer.

L. The 2% of the alcohol not burned is released from the lungs as a vapor resulting in the typical alcoholic breath odor. Some of the unburned alcohol reaches the skin and is added to perspiration in the sweat glands. The rest passes into the kidneys and is exerted in the urine.

M. Hangover occurs - 4-12 hours after the peak blood-alcohol level has been passed. Airlines prohibit pilots from flying for 24 hours after drinking and do spot tests to be sure.

IV. Alcohol and the diet

A. Alcohol irritates the lining of the stomach. This upset decreases the person's craving for food so he does not eat resulting in a period of starvation.

B. The body tissues of an alcoholic suffer for food for growth and repair as well as for vitamins and minerals needed for normal activities.

C. Alcohol contains only carbohydrate or calories (dissolved in water) and essentially no other nutrients. Although it is oxidized in the body to yeild energy, it is not a food. It does not build or repair body tissues or regulate work of cells (as vitamins do). In fact, it interferes with the work of vitamins. Its only function is for energy, but this energy is merely lost in heat.

D. Beer has about 105 calories per 8 ounce glass. Two beers have more claories than a piece of pie, a cream puff, or a candy bar and not as many nutrients.

E. The body does not store alcohol, but the calorie excess may eventually be converted to fat resulting in the typical "beer belly."

F. Alcoholics starve themselves during long periods of excessive drinking causing their livers to be drained of stored food. This may lead to several disorders:

1. Cirrhosis
    a. Hardening of the liver. The liver tissue changes in form. First it enlarges and then it shrinks in size causing hardening and scarring.
    b. This disorder is 8 times as common in alcoholics as in non-drinkers - although, drinking is not its only cause.
2. Fatty liver -
    a. Even more common liver change in alcoholics.
    b. Liver swells as fat replaces foods normally stored there.
    c. Found in about 75% of all alcoholics.
3. Gastritis
    a. Alcohol causes an abnormally large flow of hydrochloric acid in the stomach. This causes irritation of the lining of the stomach since there is usually no food for it to act on.
    b. Ulcers may also result from this. Throat and stomach cancer are more common among heavy drinkers.
4. Nervous disorders
    a. Vitamin starvation may lead to nerve diseases, reduced growth and repair of body tissues, and increased chance of infection.
    b. 1 out of 5 alcoholics develops serious disorders due to vitamin deficiencies (especially B-Complex).
    c. Some common nervous disorders seen among alcoholics:
        1. Beriberi - a lack of vitamin B_1 thiamine.
        2. Neuritis - often accompanies beriberi. Nerves are inflamed and degenerate. Not only due to lack of proper dietary intake, but alcohol interferes with normal absorption of vitamins. Thiamine is needed for the burning of carbohydrates and alcohol in the tissues. Therefore, the alcoholic needs even more thiamine than the normal person to burn up all this carbohydrate from the abundance of alcohol he drinks.
        3. Pellagra - vitamin P-P (Niacin) spotty reddening of the skin, paralysis (especially of the hands and feet), emotional upset, and possibly mental illness.

- V. General effects of alcohol
  - A. Disturbed digestion
  - B. Increased reaction time
  - C. Decreased muscular control and coordination
  - D. Impaired judgment
  - E. Weakened self-control
  - F. Dulled vision
  - G. Impaired hearing
  - H. Thickened and slurred speech
  - I. Loss of consciousness
  - J. Slowed vital processes
  - K. Death if enough alcohol has been consumed in a short time
- VI. Why do some people drink?
  - A. "My friends do - I want to be like others."
  - B. "It's socially smart."
  - C. "It's something to do."
  - D. "It helps me to relax when I'm wound up."
  - E. "I can't do without it."
  - F. Mass media and advertisements glamourize drinking and try to reinforce observations that drinking is the thing to do to be popular and successful.
  - G. Some use it to solve or avoid social or economic problems or difficulties.
  - H. Some use it as a release from tension, anxiety, inferiority feelings, etc.
  - I. Release from shyness.
  - J. Teenagers tend to think of it as an adult social act and if they drink then it means they are adults.
  - K. Some use it as part of their religion.
  - M. Some use it as a means of rebelling against authority and not because they really like it.
- VII. Why some people do not drink.
  - A. Some people think it is a social evil.
  - B. Some teenagers know their parents won't let them have the car if they drink.
  - C. Some people can't drink for health reasons and others feel it is generally better for their health if they do not.
  - D. Religious views.
  - E. Some want to avoid excesses.
  - F. Some just by preference choose not to drink.
  - G. Some do not like the taste.
  - H. Some are allergic to alcohol.
  - I. Occupational choice in life does not permit it.
- VIII. Teenage drinking
  - A. 20-84% of all teenagers drink.
  - B. 2/3 of those over 16 years use alcohol.
  - C. Most taste alcohol first at home and pattern their drinking after that of their parents or adults in prestige positions.

D. Most have their first drink at 13-14 years of age.
E. Teenagers who tend to become alcoholics later in life:
  1. Had poor adjustment to school or quit. However, their poor adjustment was not due to low I.Q. (intelligence).
  2. They enjoyed defying adults.
  3. Do not come from "poor-mixed-up" homes - homes were average.
  4. Parents were not always alcoholics.
  5. Most charges for drinking are against older boys.
F. One least likely to drink:
  1. Girl
  2. Whose parents do not drink
  3. Who is Protestant
  4. Who lives in a rural area middle-class home.
G. One most likely to drink.
  1. Boy
  2. Whose parents both drink.
  3. Who is Catholic or Jewish.
  4. Who lives in a city home where the income is either quite high or quite low.

IX. Drinking and driving
  A. National Safety Council - estimates that approximately 1 out of 4 fatal accidents involve drivers or pedestrians who had been drinking. Other estimates run as high as 50%.
  B. Alcohol lowers driving efficiency by:
    1. Giving a false feeling of security.
    2. Making him discourteous.
    3. Increasing his reaction time.
    4. Decreasing visual ability and distance judgment.
    5. Causing his mind to be on everything else but his driving.
    6. Making it harder for the drunken driver to associate danger signals with danger.
  C. Legal blood alcohol levels:
    1. 0.08-0.09% - driving while impaired or under the influence of alcohol.
    2. 0.10% and above - legal intoxication or driving while intoxicated. License can be revoked and after 1/2 year the person must file for a completely new one. If this occurs two times in ten years, it is considered a felony and the person loses all of his rights as a United States citizen (can't vote, own property, have a license, etc.) and he is committed to prison for 3 1/2 years.
    3. Most states have set the blood alcohol level at .15% as the legal limit for drunkeness, but it is .10 in New York State.
  D. To determine the amount of alcohol in the body, the breath, urine, or blood of a person is tested. The balloon or breathalyzer test is quite often used because it is rapid and simple.

  E. Police, etc. cannot make you submit to any test since as an individual you cannot be made to testify against yourself.

  F. However, if a person refuses to submit, he loses his driver's license which is a right granted by the state and, therefore, it can be taken away by the state if the person does not comply with state wishes.

X. Alcohol and crime
   - A. F.B.I. estimates that about 1/3-1/2 of all crime in the U.S. is associated with alcohol - disorderly conduct, assault, robbery. burglarly, sex crimes, and murder. Authorities feel this is true because such crimes are the result of behavior without intelligent control.
   - B. People behave differently under alcohol depending on their emotional make-up. For example, if a person is basically mean and resentful, he mav become brutal since alcohol often gives a coward a feeling of brute power.
   - C. It is estimated that 70% of the cost of maintaining city and county jails is for housing drunks, derelicts, and criminal alcoholics.

XI. Alcohol and insurance risks.
   - A. If you drink to excess, the odds are against your living to normal old age:
     - 1. Chances of accidental death are higher.
     - 2. Resistance to infection is lowered.
     - 3. Increased chance of organic disease such as ulcers or cirrhosis.
   - B. When you take an exam for life insurance you are asked: "Do you use alcoholic beverages?" If so, How often?

XII. Alcohol and the family
   - A. If both parents drink heavily, the children are often neglected.
   - B. If one parent drinks heavily, the other becomes resentful and loses respect and separation or divorce may result.
   - C. Financially, the average parent doesn't earn enough to provide for his family and for regular drinking as well. It cuts into the household budget to pay the liquor bill depriving the children of things they need leading to arguments and general family upset. If the wage-earner is the drinker, the problem is more acute since drinking lowers his work efficiency and causes absences from work.

XIII. Alcoholism
   - A. A disease with peculiar characteristics:
     - 1. Not all people who drink develop it.
     - 2. There are many causes.
     - 3. It affects different people in different ways.
     - 4. Recovery can't be predicted.
     - 5. It isn't cured by any standard treatment.
   - B. There are approximately 12 million alcoholics in the U.S.-more in cities.
   - C. It takes an average of 3 to 10 years to become an alcoholic, but it can be accomplished more quickly.
   - D. An alcoholic is a sick individual who uses alcohol to such an extent that it interferes with a successful life and he is either not able to recognize this effect or is not able to control his consumption although he knows its disastrous effects.
   - E. Alcoholism does not come in bottles, it comes in people who meet the following description:
     - 1. Repetitious drinking.
     - 2. Can't stop or help himself/herself.
     - 3. Lets alcohol interfere with interpersonal relationships.

G. What type of person is likely to become an alcoholic:

   1. Can't live in a competitive world - can't face frustrations and disappointments.
   2. Is suspicious, distrustful, and jealous.
   3. Is stubborn, has persecutory delusions, and blames others for his failures.
   4. It neurotic and may have latent homosexuality; sexual immaturity.
   5. Is trying to get away from his real self or the real world.
   6. Is immature, dependent, self-conscious, impatient, and feels inferior.
   7. Is unhappy, insecure, maladjusted, etc.
   8. Hostile and often depressed.
   9. May have schizoid like tendencies - basic sense of estrangement from people.

H. Alcoholics are addicts - without alcohol they go through withdrawal-shakes, severe pain, nausea, vomiting, headache: They have both physical and psychological dependence.

I. The psychological dependence is a vicious circle - in alcohol there is a form of escape even though the person may not like or enjoy alcohol.

   1. He feels carefree and relieved of his burdens when he uses it.
   2. If he has been thwarted and rejected in life, he feels important and dominating under the influence of alcohol.
   3. Between periods of drinking, he is more depressed than ever (nervous and irritable) and drinks more and more leading to personality degeneration and misery.
   4. The longer this continues, the less he is able to assume responsibility and meet obligations.

J. In the bottle, discontent seeks for comfort, cowardice for courage, and bashfulness for confidence.

K. Besides the psychological problems, the alcoholic is more prone to other diseases such as pneumonia and respiratory infections and his chances for recovery from disease or accidents is lessened.

L. Pre-alcoholic characteristics are different from those who do not become alcoholics:

   1. Tendency to have their first drink later in life than the non-alcoholic.
   2. Fewer had their first drink at home with their parents.
   3. They often had their first drink with an older person or persons or when alone.
   4. Frequently had their first drink in an "odd place".
   5. Frequently got drunk or sick the first time they drank.

M. Three main preliminary steps to alcoholism:

   1. Sociable drinking.
   2. Drinking to relax and relieve boredom.
   3. Drinking to escape feelings of guilt, inferiority and tensions resulting from frustrations, fear and anxiety.

N. A clear pattern emerges in "13 Steps to Alcoholism".

   1. He has begun to drink.
   2. He starts having blackouts.
   3. He finds that liquor means more to him than to others.
   4. He consistently drinks more than he means to.
   5. He starts excusing himself for drinking.

6. He starts taking "eye-openers."
7. He begins to drink alone.
8. He gets "antisocial" when he drinks.
9. He starts going on benders.
10. He knows deep remorse and deeper resentment.
11. He feels deep, nameless anxiety.
12. He realizes drinking has him licked.
13. He gets help or goes under.

O. Alcoholic Psychosis
   1. 1 out of 10 alcoholics develop this acute form of mental illness.
   2. The exact cause is not fully understood - partly due to the toxic effect of alcohol on nerve tissue and general deterioration of parts of the brain. In part due to deficiency of B-complex vitamins essential for normal nerve activity.
   3. He is confused and may not even be able to recognize members of his own family and he may not even know who he is.
   4. He has terrifying hallucinations - mostly visual and tactile.
   5. Delirium Tremens - D.T.'s - he usually thinks that moving animals are about to attack him. Last 3-10 days. Full of fear, terror, and he perspires profusely.
   6. Death may result from heart failure, pneumonia, or "wet brain" - edema.
   7. He has loss of memory for recent events and, therefore, he invents stories to fill in the gap in his thinking resulting from his memory loss.

P. Treatment for alcoholism
   1. Tranquilizers, psychotherapy, and rigid regulation of the diet with vitamin supplements. Some authorities argue against the use of other drugs as they tend to replace alcohol as the crutch.
   2. Emetics - Emetine, Antibuse, etc. Drugs which cause reverse peristalsis or vomiting when alcohol is taken with them in the system.
   3. Most states have special agencies for the purpose of carrying on studies,research, and treatment.

Q. For every alcoholic, there are 5-10 other people affected by him.

R. AA- Alcoholics Anonymous
   1. 1935 - Ohio surgeon and New York stockbroker.
   2. Many thousands of alcoholics have been helped to recover with the aid of this organization.
   3. The main purpose of AA is to help the alcoholic to stop drinking.
   4. AA contention is "It's not the drinking, but the thinking that's the stinking."
   5. Hitting bottom is fundamental to permanent cure.
   6. Steps to being helped:
      a. He admits he needs help and he is overpowered by alcohol and that alcohol is ruining his life.
      b. He notifies an AA member and asks for help.
      c. He acknowledges that he needs help from a power greater than himself.
      d. He attends regular meetings with other alcoholics and is ready to help another.
      e. He is never called a weakling or drunken bum.

    f. He is encouraged to find a new life in which there is no room for alcohol.

S. Al-Anon-organization for the spouses of alcoholics.

T. Al-teen-organization for the children of alcoholics.

U. Jewish, Chinese, and Italians - rates of alcoholism are far below average although they often use alcohol. French and Irish rates far above average.

HO-22

COMPLIMENTS OF
TARKY LOMBARDI, JR.
SENATOR 50th DISTRICT

State of New York
COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION
Office of Alcoholism and Substance Abuse

Alcohol and Substance Abuse Fact Sheet Series

ALCOHOL: SOME FACTS

Alcohol is the most popular drug in America, Europe and most other parts of the world, with only a few countries prohibiting its use. It is also the drug which causes the most accidents, addictions and deaths. More people in the United States die each year as a result of alcohol than from all illegal drugs combined.

Many people do not feel alcohol is a drug, even though they use it and may sometimes become drunk, or stoned. Others feel that it is a drug, but is a "special" drug that is not at all like the illegal ones. Still other people feel that only strong liquors like Vodka and Scotch are bad for health, but that beer and wine are not harmful. All of these opinions are wrong.

Alcohol is a drug, and a very potent one. Until earlier in the 20th century, it was often used by doctors to kill pain. It was replaced by other drugs for this purpose, however, when better ones were invented.

Alcohol also takes certain vitamins and minerals out of the body, such as Vitamin C, calcium pantothenate, Vitamin A, and others. Alcoholics often have many chronic problems caused by vitamin deficiencies, and even those who drink much less must be careful to watch their vitamin intake.

Alcoholic drinks have some good and many bad uses, all depending on the person involved and how much is used. This is the exact same rule for almost every other drug that can make a person high; it depends on how much, how often, and the personality type of the user, plus other factors. The substance itself is just like any other drug, neither good nor bad. Alcohol in small amounts can make many people relax, or help overcome a feeling of being nervous at a party or dinner. But there are other techniques for relaxing that may work just as well if you learn them, such as mental exercises, and breathing techniques.

Sometimes people try to get rid of their problems by drinking. This works at first, but only when you are drinking, and the next day the problems come back again. After awhile there is a new problem on top of the old one: Alcoholism. This is an addiction that acts in much the same way as addiction to other drugs, such as heroin and barbiturates. The addicted person cannot go for very long without more and more of the drug. If the drug is stopped, then withdrawal starts. There is pain, and a danger of grand mal (large) convulsions, which are sometimes deadly unless a doctor is helping the withdrawal in a hospital.

Alcohol causes overdoses very often. It also makes people sick when they drink too much. Sometimes people get sick and then throw up after they pass out, which can be very dangerous. If a person has passed out he/she may be facing upward, sleeping. Then if they throw up, they may inhale it and suffocate without waking up. It is always safest to place a person who has passed out after drinking on their stomach, with the head turned so that this type of suffocation cannot happen.

It is also deadly to drink and use other drugs at the same time. This is a problem with people who use legal drugs as well as the illegal ones. Alcohol should never be used if a person is taking sleeping pills of any kind (usually barbiturates), Valium, Librium, methaqualone (Quaaludes, Sopors, etc.), PCP or Angel Dust, Thorazine, Stellazine, Elavil, Triavil, and other drugs which are either mild or heavy downers, including heroin.

The problem with mixing drugs is that the liver cannot filter out the drugs at the normal rate, since it is also working hard to get rid of the alcohol. People die of overdoses since their bodies cannot handle both chemicals at the same time, and a reaction takes place that makes the drugs seem stronger than they originally were. The number of drugs needed, and the amount of alcohol used to overdose, is different for every person.

You may hear of people who believe in strict abstinence. That is, they never drink even a little bit. This is of course a good idea, but it may not be right for everybody. There is no evidence that occasional use of alcohol of any kind, in small amounts, will be harmful. You should make up your mind about this on your own, and not as a result of pressure. Drinking because someone tells you to is never a good thing, either.

What if your parents use alcohol, but insist this is all right for them, but not for you? Many parents feel that alcohol should not be used by their children until they are legally old enough for it according to the law.

Other parents see alcohol use as all right for their children on occasion (a taste sometimes), but do not feel it is a drug. Therefore, they may say that it is all right for them to use alcohol, and for you to find out about it, but they warn you to never use drugs. This is because they see the difference between a "good" drug and a "bad" drug according to whether it is illegal.

Many different kinds of opinions exist about alcohol and every other type of legal or illegal drug. New facts are always being discovered. So what people used to believe was true is not always true today.

It is known today that many young people who have one or both parents who suffer from alcoholism may tend to be alcoholics themselves later in life. Special help is available from a group called Alateen, a division of Al-Anon, an organization for families of alcoholics. There are chapters in many areas. Alcoholics Anonymous or your local alcohol organization will be able to identify the nearest Alateen chapter.

It is hard to say what attitudes everyone's parents will have. Hopefully your parents will want to discuss alcohol facts and drug facts and give you good reasons for everything discussed. If not, it is up to you to learn all you can.

For more information about alcohol, write or call your local chapter of the National Council on Alcoholism, or write to the National Institute on Alcohol Abuse and Alcoholism, Box 2345, Rockville MD 20852.

In New York State, more information about alcoholism can be obtained by writing the NYS Division of Alcoholism, 44 Holland Ave., Albany NY 12229.

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NAME: ____________________

DATE: ____________________

PERIOD: ____________________

ALCOHOL QUIZ

_____ 1. Alcohol is a stimulant.

_____ 2. Alcohol is a drug.

_____ 3. Alcohol is a serious problem for today's teenagers.

_____ 4. You can only become alcoholic by drinking the "hard stuff".

_____ 5. Alcohol is a factor in 25-50% of traffic deaths.

_____ 6. Chronic alcoholism is a form of drug addiction.

_____ 7. Alcohol causes alcoholism.

_____ 8. Most "alcoholics" are down-and-outers, the town drunks, the skid row bums.

_____ 9. The organ most responsible for eliminating the alcohol from the body is the lung.

_____10. With the desire to be helped and proper treatment, most alcoholics can be cured.

Name: ____________________

Date: ____________________

Period: ____________________

ALCOHOL QUIZ

__F__ 1. Alcohol is a stimulant. (Depressant)

__T__ 2. Alcohol is a drug.

__T__ 3. Alcohol is a serious problem for today's teenagers.

__F__ 4. You can only become alcoholic by drinking the "hard stuff." (The alcohol is the same regardless of the beverage).

__T__ 5. Alcohol is a factor in 25-50% of traffic deaths.

__T__ 6. Chronic alcoholism is a form of drug addiction.

__F__ 7. Alcohol causes alcoholism. (Or everyone who drinks would be alcoholic).

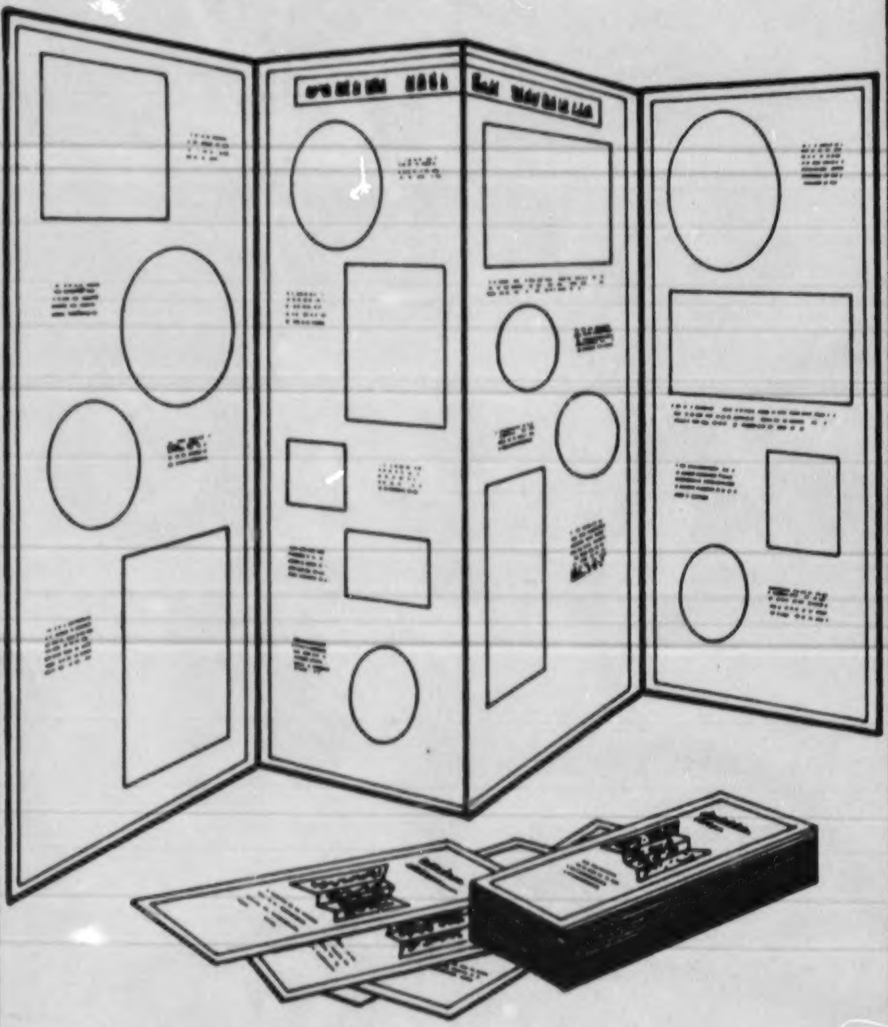
__F__ 8. Most "alcoholics" are down-and-outers, the town drunks, the skid row bums. (Everyday people).

__F__ 9. The organ most responsible for eliminating the alcohol from the body is the lung. (Liver).

__F__ 10. With the desire to be helped and proper treatment, most alcoholics can be cured. (Treated, "yes", but not cured!)

MEDICAL HAZARDS WITH ALCOHOLISM

BY W. R. SPENCE, M. D.



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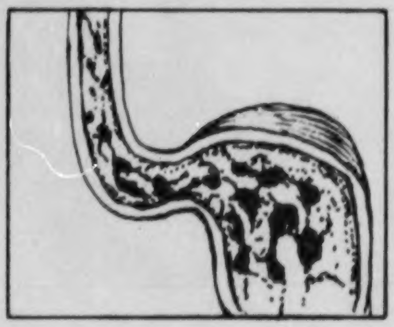
Alcoholism is a disorder characterized by repeated drinking of alcoholic beverages to an extent that it interferes with the drinker's physical health, emotional health and social functioning. Most alcoholics are not derelicts, but are married, have a job and go to church. When taken as a group, the diseases associated with alcoholism constitute the third leading cause of disability and death in America.

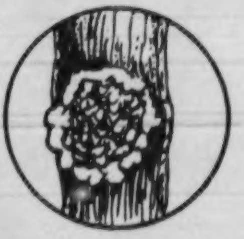


VARICOSE VEINS OF THE ESOPHAGUS

Cirrhosis of the liver produces a secondary increase in blood pressure in the veins of the esophagus (food tube leading from the throat to the stomach). This pressure causes the veins to become stretched and dilated (varicose). Death from internal hemorrhaging may occur if these thin, ballooned-out veins rupture.

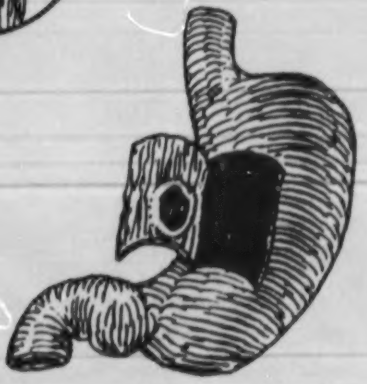
CANCER OF ESOPHAGUS

Due to an unknown chemical quality in alcoholic beverages, alcoholics have a far greater chance of developing cancer of the esophagus than do nonalcoholics. Cancer causes difficulty in swallowing and a sensation of blockage behind the sternum. Surgery is the only treatment, and the cure rate is very low.



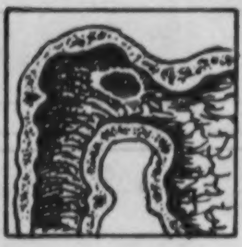
GASTRIC ULCERS

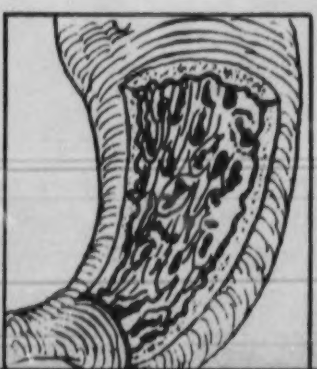
Alcohol is extremely irritating to the stomach and causes an over-secretion of stomach acids and enzymes. This increased acidity causes ulcers and prevents healing of existing ulcers. Stomach ulcers may hemorrhage, perforate, or obstruct passage of food. No ulcer patient should drink.



DUODENAL ULCERS

The duodenum is the first part of the small intestine which receives food from the stomach. Ulcers develop here for the same reason they develop in the stomach. Bleeding, obstruction, and perforation may be fatal complications of duodenal ulcers if patients continue to drink.

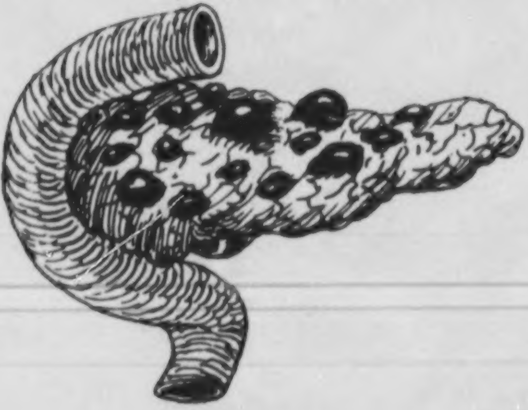




GASTRITIS

Heavy drinking is the most common cause of serious inflammation of the lining of the stomach. The mucosa becomes reddened with bleeding areas covered with thick, ropy mucus. Symptoms include nausea, vomiting, headache and pains in the stomach.

MEDICAL HAZARDS



PANCREATITIS

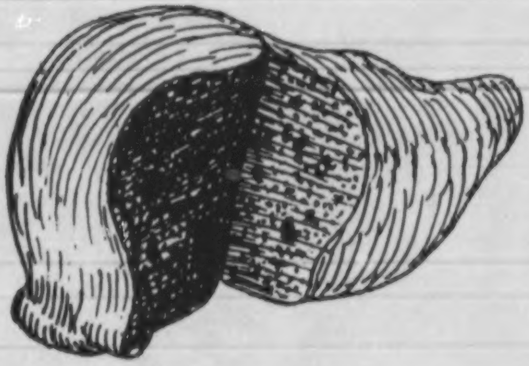
The pancreas is a small organ lying in the uppermost portion of the abdomen, stretching from the duodenum on the right to the spleen on the left. It produces insulin and digestive enzymes vital to life. Inflammation of the pancreas is a serious illness characterized by severe abdominal pain, nausea and vomiting. Alcohol is directly poisonous to the pancreas, and 40% of pancreatitis patients are alcoholics.

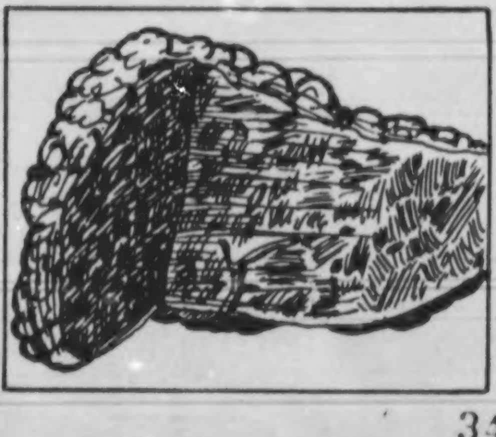
ALCOHOLIC HEPATITIS

This condition is characterized by fever, jaundice, swelling in the abdomen, and swelling of the feet. The liver is generally large, firm, tender and infiltrated with fat. Many patients die from this illness, some recover and other progress to develop cirrhosis.

FATTY LIVER

Excessive intake of alcohol can cause the liver to be infiltrated with droplets of fat. The liver becomes large and tense, and its color varies from yellow to green. When cut, the liver has doughy consistency, owing to the high fat content. Fatty liver may give few symptoms early in its course, but if drinking continues this abnormality will progress to cirrhosis and eventually to death.





CIRRHOSIS

Cirrhosis is the seventh leading cause of death in America. Alcohol is the leading cause of cirrhosis. The cut surface of the liver may enlarge or shrink, depending on the stage of the disease. The outside surface is frequently rough and wrinkled like a prune. Symptoms include loss of weight, chronic nausea, vomiting, weakness, loss of sex drive, abdominal pains, bloating of the abdomen and hemorrhaging.

WITH ALCOHOLISM

DEGENERATION OF THE CEREBELLUM

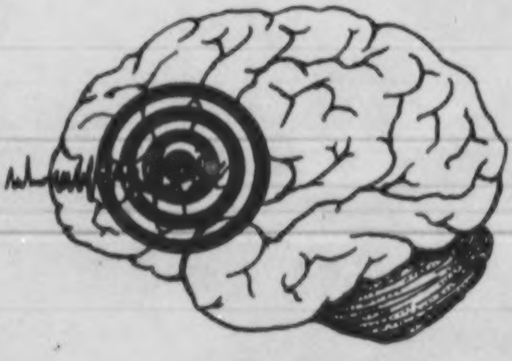
The cerbellum is the portion of the brain at the rear of the skull which controls equilibrium. Chronic alcoholics may develop a withering of the top portion of this organ with permanent loss of coordination.

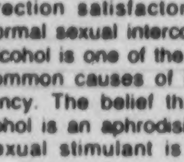
NEURITIS

Prolonged intake of alcohol has a direct poisonous effect upon the nerves in the arms and legs. Symptoms include tingling, pins and needles sensations, burning, itching, numbness, weakness and paralysis. Treatment involves complete abstinence from alcohol, improved nutrition and vitamin supplementation.

DELIRIUM TREMENS

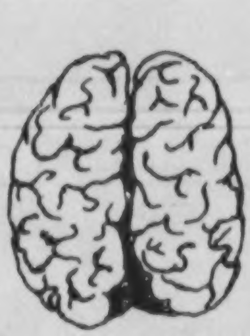
Withdrawal from alcohol can cause physical and emotional suffering worse than withdrawal from heroin. The DT's begin with tremors, sweating and nausea. They progress to insomnia, profound confusion, delusions, hallucinations and convulsions. This serious complication may be fatal approximately 10% of the time.





IMPOTENCY

Impotency refers to the inability of a man to sustain an erection satisfactory for normal sexual intercourse. Alcohol is one of the most common causes of impotency. The belief that alcohol is an aphrodisiac or sexual stimulant is pure nonsense. In acute alcoholism, the impotency may be caused by the depressant effect of the drug. In chronic alcoholism, impotency may be caused by neuritis, liver damage, malnutrition and other complications.



BIRTH DEFECTS

Many babies born of alcoholic women have abnormal development. They are underweight and their brain size is less than normal. The development of the heart may be incomplete and there may be a cleft palate. They continue to grow at a slower pace after birth and end up as smaller adults. Alcohol passes through the bloodstream of the mother into the uterus and placenta and directly into the unborn child. Pregnant women should avoid all drugs, including alcohol, particularly during the first three months of pregnancy.

ACCIDENTS

Alcohol is a contributing factor in approximately 20% of all falls, 20% of accidental asphyxiations, 20% of drownings, 20% of deaths from freezing, 25% of deaths attributed to choking on foods, 50% of all fire deaths, and well over 60% of all fatal automobile accidents.

SUICIDE

Suicide is the tenth leading cause of death in America and the third leading cause of death below the age of 30. Alcohol is a factor in over 60% of all suicide attempts, successful and unsuccessful.

CHILD ABUSE

Approximately 1 in every 100 American children are physically and psychologically severely abused at least once. Excessive drinking is a major factor in a large majority of these cases.

MURDER

Murder is the twelfth leading cause of death in America and the fourth leading cause of death below the age of 30. Alcohol is implicated in over 70% of all murders and other violent crimes.

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TEST QUESTIONS

Take this exam before and after reading the text.

T F 1. Alcoholics have a far greater chance of developing cancer of the esophagus than do nonalcoholics.
T F 2. No ulcer patient should drink.
T F 3. In alcoholic hepatitis, the liver is generally small, soft, and reddened.
T F 4. Cirrhosis is the twelfth leading cause of death in America.
T F 5. Delirium tremens begin with tremors, sweating, and nausea, and progress to confusions and hallucinations, but this problem is very rarely fatal.
T F 6. Alcohol is a sexual stimulant.
T F 7. Babies born to alcoholic mothers are often maldeveloped, with a brain less than normal size.
T F 8. Suicide is the third leading cause of death below age 30.
T F 9. Murder is the fourth leading cause of death below age 30.
T F 10. Approximately one in every 500 American children is physically and psychologically severely abused at least once.

ANSWERS:
(1)T (2)T (3)F (4)F (5)F (6)F (7)T (8)T (9)T (10)F

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Name: ____________________

Per.: __________

Fetal Alcohol Syndrome: A study guide

1. What are some characteristics of a child afflicted by the Fetal Alcohol Syndrome?

2. What is "Thalidamide", and how does the film compare it to alcohol?

3. Is the Fetal Alcohol Syndrome reversible?

4. Is it damaging for a woman to drink moderately while she is pregnant? Why or why not?

HO-27

Fetal Alcohol Syndrome

HEALTH

GENERAL SCIENCE

SOCIAL STUDIES

Objectives

To discuss the symptoms of fetal alcohol syndrome.

To study case histories of fetal alcohol syndrome.

To explore methods of alleviating the syndrome.

Highlights

Although he has two eyes, two ears, two arms and two legs, Kenneth is not a normal child. He is almost two years old, but he only has the abilities of an eight-month-old infant. His mind and body were crippled before birth by his mother's disease: chronic alcoholism. Kenneth is a victim—and a representative—of fetal alcohol syndrome.

While she was pregnant, Kenneth's mother was drinking half a gallon of wine every day. At birth, Kenneth weighed only half as much as a normal child. The overall length of his body remains shorter than average, and his facial profile is relatively flat. Kenneth's eyelids droop, and his eye slits are too short. Worst of all, his brain is permanently damaged; his capabilities are severely limited for life.

Dr. David Smith of the University of Seattle has conducted research into the causes and symptoms of fetal alcohol syndrome. Before the syndrome was discovered and named, birth defects like Kenneth's were largely a mystery. Doctor Smith believes that of the babies born to mothers who were "chronically alcoholic throughout pregnancy," one third to one half will suffer from fetal alcohol syndrome.

Dixie Holiday experiences difficulty holding a pencil. She forgets easily, and is unable to play with other children. Dixie's father and stepmother bring her to Doctor Smith in Seattle, and Doctor Smith diagnoses fetal alcohol syndrome. The disease affects the total body structure and also the brain. Doctor Smith believes its importance is vastly underrated.

Experiments relating to Doctor Smith's work have been carried out on pregnant mice. Some of the mice were given moderate amounts of alcohol, some were given heavy amounts, and some were given no alcohol at all. The offspring of the mice given "heavy" amounts tended to be damaged. These findings in no way "prove" Doctor Smith's hypotheses, but they certainly correlate with them.

"It never entered my mind that my drinking might affect my unborn child," confesses the mother of a five-year-old daughter suffering from fetal alcohol syndrome. The mother blames her doctors for not informing her of the danger. Prospective mothers should be questioned as to their habits, she says, and their blood regularly tested for its alcohol content.

Applications

Recognizing Symptoms What are some physical symptoms of fetal alcohol syndrome? How does fetal alcohol syndrome affect the brain? What is "chronic alcoholism"? Is it a disease? Why or why not? What are some methods for testing the abilities of young children? How long do the effects of fetal alcohol syndrome last? Why do you suppose it took so long to discover fetal alcohol syndrome? What are some birth defects not caused by fetal alcohol syndrome?

Kenneth and Dixie How is Kenneth different from other children his age? How would you describe his facial profile? His eyes? Who and what are responsible for Kenneth's condition? What is the prognosis for his future? What is a "case study"? How does a case study differ from a fictionalized account? What are some of Dixie's symptoms? Why do you suppose it took so long for her parents to contact a doctor?

Who Can Help? What are some of Dr. David Smith's findings about fetal alcohol system? Where does Doctor Smith practice? Why does he believe fetal alcohol syndrome is more serious than generally supposed? What were the results of the experiments with pregnant mice? How do these results relate to Doctor Smith's independent findings? Why aren't mothers more aware of fetal alcohol syndrome? Who should tell them? Why are blood tests so important?

16mm Color No. 322-0148 13 minutes
Producer: National Broadcasting Company

Related Films
Alcohol: Drug of Choice (323-0003)
The Exceptional Child (323-0013)
Pregnancy and Birth (101-0009)

FILMS INCORPORATED
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WILMETTE, ILLINOIS 60091
312/256-4730

DRINKING PHASES OF ALCOHOLISM

EARLIEST DANGER SYMPTOMS	MIDDLE STAGES	LATE STAGE
1. Feeling that parties or other festive occasions aren't complete without a few drinks.	1. Heavier drinking is more noticeable to others. Individual resents being told about it and develops "explanations" to himself and others for his drinking behavior.	1. The individual now gets drunk on less alcohol, and length of drinking bouts increases.
2. More frequent use of drinking to "relieve" tension and fatigue; to "get over" disappointment, frustration, home and business quarrels.	2. When starting to drink, he now gets first few down quickly; sometimes prefers drinking to eating.	2. He feels depressed, guilty and/or sick most of the time, and relieves these feelings with more alcohol.
3. Ability to handle more alcohol than others and a need to have a "few extras" when drinking with others.	3. He wants to have alcohol available at all times and feels uncomfortable when it is not; drinks to calm unexplainable fears and "nerves".	3. Neglect of eating; obsession with fears; anxieties and resentments; inability to get going during the day without a drink or drinks.
4. Beginning of blackouts when parts of the previous evening cannot be remembered although the individual did not pass out.	4. He makes unsuccessful attempts to cut down on drinking; has increasing difficulty with job, family and others.	4. Constant tremors, relieved only by drinking; severe deterioration of health, family, work and other relationships.

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A PROFILE OF THE PROBLEM DRINKER

PRE-ALCOHOLIC SYMTOMS	ALCOHOLISM	
	EARLY STAGES	LATER STAGES
1. Gross drinking behavior	5. Loss of control	12. Benders
2. Blackouts	6. Alibi system	13. [illegible]rs - "shakes"
3. Gulping and sneaking drinks	7. Eye-openers	14. Protecting supply
4. Hangover	8. Changing the pattern	15. Unreasonable resentments
	9. Anti-social behavior, solitary drinking	16. Nameless fears and anxieties.
	10. Loss of friends-jobs	17. Collapse of alibi system (admission to self that drinking is beyond control).
	11. Medical aid	18. Surrender process

A PROFILE OF THE PROBLEM DRINKER

What is a problem drinker? A person whose excessive drinking repeatedly interferes with his health or personal relations, and whose work is thereby reduced in efficiency and dependability. He may be a key executive, a skilled worker, a foreman or an engineer. Though problem drinkers are not necessarily alcoholics, all alcoholics can be classed as problem drinkers.

The problem drinker can be helped, but, as in any disease, the symptoms must be discovered before help can be given. The steps of an alcoholic's progress show a definite pattern of drinking behavior.

PRE-ALCOHOLIC STAGE

The first steps toward alcoholism begin when drinking is no longer social, but psychological . . . a release from tension and inhibition. Though still in reasonable control of his drinking, the problem drinker begins to show a definite behavior pattern. These pre-alcoholic symtoms include:

1. GROSS DRINKING BEHAVIOR

   Begins to drink more heavily and more often than his friends. "Getting tight" becomes a habit. When drunk, he may develop a "big-shot" complex, throw his money around, make pointless long distance calls and so on.

2. BLACKOUTS

   Starts forgetting what happened "the night before." These blackouts are not the result of passing out, but a sort of amnesia. They sometimes happen to ordinary drinkers, but in people moving toward alcoholism they tend to develop into a pattern.

3. GULPING AND SNEAKING DRINKS

   More and more dependent on the pampering effects of alcohol, he tends to "toss-off" his drinks, rather than sip them. Sneaks extra drinks, or has a couple before the party. Feels guilty; avoids talking about drinking.

4. CHRONIC HANGOVER

   As he becomes more and more reliant on alcohol to cushion the shocks of daily living, the "morning after" becomes increasingly painful and more frequent. This is the final danger signal: Next step - alcoholism.

EARLY-STAGE ALCOHOLISM

Until now the problem drinker has been drinking heavily, but not always conspicously. More important, he has been able to stop drinking when he chooses, but beyond this point, he will develop the symptoms of early-stage alcoholism with increased rapidness:

5. LOSS OF CONTROL

   This is the mark of the alcoholic. In this phase, he can refuse to start drinking, but can't stop drinking once he starts. A single drink is likely to trigger a chain reaction and he will drink himself to complete intoxication.

6. ALIBI SYSTEM

   He feels guilty and defensive about his lack of control. Erects an elaborate system of "reasons" for drinking, partly to answer family and associates, but mostly to reassure himself.

7. EYE OPENERS

   Needs a drink in the morning to "start the day right". This "medicinal" drink helps kill the effect of increasingly painful hangovers; feeling of guilt, remorse, depression. He cannot face the day without it.

8. CHANGING THE PATTERN

   Under pressure from family or employer, he tries to break the hold alcohol has on him. Sets up rules on when or what he will drink. May go "on the wagon" for a period, but one touch of alcohol can start the chain reaction again.

9. ANTI-SOCIAL BEHAVIOR

   He prefers drinking alone, or with other alcoholics whatever their social level. Broods over imagined wrongs. Thinks people are staring at or talking about him. Is highly critical of others. May become destructive or violent.

10. LOSS OF JOBS AND FRIENDS

    His continuing anti-social behavior causes him to be dropped from jobs, and leads his friends to turn away from him. As a defensive measure, he may quite before he can be fired; drop his friends first.

11. SEEKING MEDICAL AID

    Physical and mental erosion caused by uncontrolled drinking leads him to make rounds of hospitals, doctors, psychiatrists. Seldom receives lasting benefits because he refuses to cooperate or admit extent of drinking.

LATE-STAGE ALCOHOLISM

Until he reached this point, the alcoholic had a choice: to drink or not to drink; though once he began, he had no control of his drinking. In later stages of alcoholism there is no choice: he must drink however and whenever he can. The symptoms of this stage are:

12. BENDERS

    Drinks for days at a time; gets blindly and helplessly drunk. Utterly disregards everything; family, job, even food and shelter. These periodic escapes into oblivion mark the beginning of the final, chronic phase of alcoholism: drinking to escape problems created by drinking.

13. TREMORS

    Develops the "shakes", a serious nervous condition. Alcoholic diseases often begin in this period; vitamin deficiency ailments, the DT's. After these attacks he swears off, but can't stay away from alcohol for long.

14. PROTECTING THE SUPPLY

    Having a supply of alcohol available is the most important thing in his life. He will do or sell anything to get it, and will hide his bottles to protect them for future use.

15. UNREASONABLE RESENTMENTS

    Shows hostility toward others, both as possible threats to his precious liquor supply and as a turning outward of unconscious desire to punish himself.

16. NAMELESS FEARS AND ANXIETIES

    Is constantly afraid of something which he cannot pin down or even put into words. Feels a sense of impending doom and destruction. Nervous, shakey, he is utterly unable to face life without the support of alcohol.

17. COLLAPSE OF THE ALIBI SYSTEM

    No longer able to make excuses for himself, or put the blame on others, he to himself that he is licked, that his drinking is beyond his ability to control! (May happen during earlier stages, be repeated many times.)

18. SURRENDER PROCESS

    If he is to recover at this stage, he must give up the idea of ever drinking again and be willing to seek and accept it. This must take place with the collapse of the alibi system - only when they occur together is there any hope of recovery.

HO-30

ALCOHOL AND DRIVING
(read upward from bottom of chart)

Amount of liquor consumed	Alcohol in blood-per cent	Status (when driving)	Descriptive Effects
- ? -	0.60	Illegal	Death - approximate level.
- ? -	0.50	Illegal	Alcoholic Stupor, Coma - approximate.
7 - 8 oz.	0.15	In most states Illegal	Gross intoxication - Unmistakable impairment of all physical activity and mental faculties.
5 - 6 oz.	0.10	In NYS Illegal	Serious impairment of physical and mental functions; loss of judgment and inhibitions - clumsy, uncoordinated.
2 - 3 ox.	0.05	- ? -	Exaggerated emotion and behavior - Less concern, mental relaxation. Decrease in finer skills of coordination.
0 - 1 oz.	0.01	- ? -	Mild effects - slight change in feeling. Existing mood (anger, elation, etc.) may be heightened.

The question marks in the status column indicate that impairment begins for many people at alcohol concentrations which are well below the levels acceptable in drinking groups. This has been confirmed repeatedly by driving tests in simulators and on experimental field courses.

As a result of more modern and realistic experiments, the majority of our specialists in the field of chemical tests have come to the definite conclusion that none of us is fit to drive a motor vehicle when he has as much as 0.10 percent blood alcohol - the 0.15 percent presumptive level was far too liberal.

DRIVING BEHAVIOR OF DRINKING-DRIVERS

1. Unreasonable speed (high).
2. Driving in spurts, slow, then fast, then slow, etc.
3. Frequent lane changing with excessive speed.
4. Improper passing with insufficient clearance, also taking too long or swerving too much in overtaking and passing; i.e., over-control.
5. Overshooting or disregarding traffic signals.
6. Approaching signals unreasonably fast or slow and stopping or attempting to stop with uneven motion.
7. Driving at night without lights. Delay in turning lights on when starting from a parked position.
8. Failure to dim lights to oncoming traffic.
9. Driving in lower gears without apparent reason, or repeatedly clashing gears.
10. Jerky starting or stopping.
11. Driving unreasonably slow.
12. Driving too close to shoulders or curbs, or appearing to hug the edge.
13. Driving with windows down in cold weather.
14. Driving or riding with head partly or completely out of the window.
15. The common recognition factor is out-of-the-ordinary driving.

HO-31

ALCOHOLISM TEST

The following point scale is offered as an aid to evaluate the seriousness of your drinking. Anyone who scores 25 points is either in trouble with alcohol, or approaching it. Those who score 50 points are to some extent alcohol-dependent. One hundred points indicates alcoholism.

	SCORE
One drink daily, regularly	1
Two drinks daily, regularly	5
Three drinks regularly before dinner	20
Four drinks in any one day, often	25
One drink daily before lunch	5
Two drinks daily before lunch	15
Always a drink before lunch	10
One drink daily on the way home	10
Two drinks daily on the way home	20
Look forward to a drink, often	10
Unhappy if not offered a drink before dinner	10
Usually one drink after dinner	10
Usually two drinks after dinner	15
Drink alone frequently	100
Deceitful about drinking	100
Tight or "high" three times a year	50
Compulsive drinking	100
A drink to "gird one's loins" (to meet a situation)	10
Taking a drink to sleep	10

If you associate with a hard-drinking group, add 25 points to your score.

If you are a true weekend drinker, add 20 points to your score.

If your spouse (girl/boyfriend) drinks regularly, add 15 points to your score.

TOTAL: ______

_____ I am in trouble with alcohol or approaching it.

_____ I am to some extent alcohol-dependent.

_____ I am or am becoming a confirmed alcoholic.

_____ I do not abuse alcohol according to this scale.

HO-32

CHEMICAL MAKEUP OF TOBACCO AND TOBACCO SMOKE

Name	Properties
Tar	a dark brownish-black substance obtained by destructive distillation of organic material (as wood, coal or peat), source of many chemical substances contained in tobacco smoke; a result of combustion
Nicotine	deadly poison found in tobacco leaves and responsible for some of the harmful effects of smoking
Ammonia	chemical used in manufacturing fertilizer and explosives; used as a cleaning fluid; component of smelling salts; is irritating to nasal passages; is a biproduct of cigarette smoke and is harmful to the body
Formaldehyde	powerful disinfectant gas sometimes used as disinfectant; used in some solutions as a preservative; a colorless poison; has also been used as a surgical and general antiseptic
Phenol (Carbolic Acid)	used as germicide; powerful antiseptic, disinfectant
Cresol	poisonous crystalline substance obtained from coal tar and containing not more than 5% of phenol
Benzo-Pyrene	a potential carcinogenic agent which can cause or incite cancer
Arsenic	extremely poisonous element; used in weed killer and insecticide; is also a biproduct of cigarette smoke
Cyanide	one of the most common deadly poisons known; can cause severe respiratory problems; Hydrogen Cyanide used in fumigating

SMOKE FROM THE COMMON CIGARETTE HAS BEEN FOUND THROUGH RESEARCH AND SCIENTIFIC ANALYSIS TO CONTAIN THE ABOVE MENTIONED CHEMICALS, ALL OF WHICH MAY HAVE BOTH IMMEDIATE AND LONG-RANGE HARMFUL EFFECTS ON THE SMOKER'S HEALTH.

HO-33

Federal Trade Commission Chart of CIGARETTE TAR AND NICOTINE CONTENT

Reproduced with permission from "Report of Tar and Nicotine Content of the Smoke of 176 Varieties of Cigarettes," Federal Trade Commission, December, 1979.

AMERICAN LUNG ASSOCIATION
The Christmas Seal People ®

Tar[1] and Nicotine Content of One-hundred seventy-six (176)
Varieties of Domestic Cigarettes
(shown in increasing order of tar values)

BRAND	TYPE	Tar (mg/cig)	Nicotine (mg/cig)
Carlton	king size, filter, (hard pack)	<0.5	<0.05
Carlton	king size, filter, menthol	1	0.1
Benson & Hedges	reg. size, filter, (hard pack)	1	0.1
Carlton	king size, filter	1	0.1
Tareyton Ultra Low-Tar	king size, filter, menthol	2	0.2
Now	king size, filter, menthol, (hard pack)	2	0.2
Now	king size, filter, menthol	2	0.2
Now	king size, filter	2	0.2
Now	king size, filter, (hard pack)	2	0.2
Triumph	king size, filter, menthol	2	0.3
Kent III	king size, filter	3	0.3
Triumph	king size, filter	3	0.4
Iceberg 100's	100 mm, filter, menthol	3	0.3
Lucky 100's	100 mm, filter	4	0.3
Decade	king size, filter, menthol	4	0.4
Decade	king size, filter	4	0.4
True	king size, filter, menthol	5	0.4
True	king size, filter	5	0.4
Carlton 100's	100 mm, filter, menthol	5	0.4
Doral II	king size, filter, menthol	5	0.4
Doral II	king size, filter	5	0.5
Carlton 100's	100 mm, filter	6	0.4
Pall Mall Extra Light	king size, filter	7	0.6
L & M Lights	100 mm, filter	7	0.6
L & M Lights	king size, filter	7	0.6
Tempo	king size, filter	8	0.6
Lark Lights	king size, filter	8	0.6
Lark Lights	100 mm, filter	8	0.6
American Lights	120 mm, filter	8	0.6
Tareyton Lights	king size, filter	8	0.6
Merit	king size, filter	8	0.6
Arctic Lights	king size, filter, menthol	8	0.7
Kent Golden Lights	king size, filter	8	0.7
Merit	king size, filter, menthol	8	0.6
Real	king size, filter, menthol	9	0.7
Lucky Ten	king size, filter	9	0.7
Belair	100 mm, filter, menthol	9	0.7
Kent Golden Lights	king size, filter, menthol	9	0.7
Kool Super Lights	100 mm, filter, menthol	9	0.7
Viceroy Rich Lights	king size, filter	9	0.7
Tareyton Long Lights	100 mm, filter	9	0.7
Kool Super Lights	king size, filter, menthol	9	0.7
Kent Golden Lights	100 mm, filter	9	[illegible]
American Lights	120 mm, filter, menthol	9	0.8
Raleigh Lights	king size, filter	9	0.8
Parliament Lights	king size, filter	9	0.7
Raleigh Lights	100 mm, filter	9	0.8
Arctic Lights	100 mm, filter, menthol	9	0.8
Newport Lights	king size, filter, menthol	10	0.8
Belair	king size, filter, menthol	10	0.8
Viceroy Rich Lights	100 mm, filter	10	0.8
Old Gold Light's	king size, filter	10	0.8
Real	king size, filter	10	0.9
Kent Golden Lights	100 mm, filter, menthol	10	0.8
Camel Lights	king size, filter	10	0.9
Parliament Lights	king size, filter, (hard pack)	10	0.7
Sliva Thins	100 mm, filter, menthol	10	0.8
Merit 100's	100 mm, filter	10	0.7
Benson & Hedges Lights	100 mm, filter, menthol	11	0.7
Merit 100's	100 mm, filter, menthol	11	0.8
Vantage	king size, filter, menthol	11	0.8
Benson & Hedges Lights	100 mm, filter	11	0.8
Salem Long Lights	100 mm, filter, menthol	11	0.9
Vantage	king size, filter	11	0.8
Salem Lights	king size, filter, menthol	11	0.8

[1] TPM dry (tar) - milligrams total particulate matter less nicotine and water

Tar[1] and Nicotine Content of One-hundred seventy-six (176)
Varieties of Domestic Cigarettes
(shown in increasing order of tar values)

BRAND	TYPE	Tar (mg/cig)	Nicotine (mg/cig)
Multifilter	king size, filter	11	0.8
Kent	king size, filter	11	0.9
Parliament Lights 100's	100 mm, filter	12	0.8
Marlboro Lights	king size, filter	12	0.8
Marlboro Lights	100 mm, filter	12	0.8
Vantage	100 mm, filter	12	0.9
Multifilter	king size, filter, menthol	12	0.8
Pall Mall Lights	100 mm, filter	12	0.9
Doral	king size, filter, menthol	12	0.9
Silva Thins	100 mm, filter	12	1.0
Kool Milds	king size, filter, menthol	13	0.8
Doral	king size, filter	13	1.0
Kent	king size, filter, (hard pack)	13	1.0
Eve	120 mm, filter, menthol, (hard pack)	13	1.0
Eve	120 mm, filter, (hard pack)	13	1.0
True 100's	100 mm, filter	13	0.8
Winston Lights 100's	100 mm, filter	13	1.0
Viceroy	king size, filter	13	0.9
Camel Lights	100 mm, filter	13	1.1
True 100's	100 mm, filter, menthol	14	0.8
Kent	100 mm, filter	14	1.0
Winston Lights	king size, filter	14	1.1
Tareyton	100 mm, filter	14	1.0
Tareyton	king size, filter	14	0.9
L & M	king size, filter, (hard pack)	14	0.9
Marlboro	king size, filter, menthol	15	0.9
Alpine	king size, filter, menthol	15	0.9
Kent	100 mm, filter, menthol	15	1.2
Virginia Slims	100 mm, filter, menthol	15	0.9
Eve	100 mm, filter	15	1.1
Marlboro	king size, filter, menthol	15	0.9
Saratoga	120 mm, filter, menthol, (hard pack)	15	1.0
St. Moritz	100 mm, filter, menthol	15	1.1
Chesterfield	king size, filter	15	0.9
L & M	king size, filter	15	1.0
DuMaurier	king size, filter, (hard pack)	15	1.0
Eve	100 mm, filter, menthol	15	1.1
Oasis	king size, filter, menthol	15	1.0
Virginia Slims	100 mm, filter	16	1.0
Viceroy	100 mm, filter	16	1.1
St. Moritz	100 mm, filter	16	1.1
Pall Mall	100 mm, filter, menthol	16	1.2
Salem	king size, filter, menthol	16	1.1
Newport	king size, filter, menthol, (hard pack)	16	1.2
Tall	120 mm, filter, menthol	16	1.3
L & M	100 mm, filter	16	1.0
Kool	100 mm, filter, menthol	16	1.2
L & M	100 mm, filter, menthol	16	1.0
Long Johns	120 mm, filter, menthol	16	1.4
Raleigh	king size, filter	16	1.0
Kool	king size, filter, menthol	16	1.3
Chesterfield	101 mm, filter	16	1.1
Kool	king size, filter, menthol, (hard pack)	16	1.3
Twist	100 mm, filter, lemon/menthol	16	1.3
Raleigh	100 mm, filter	16	1.1
Benson & Hedges	100 mm, filser, menthol, (hard pack)	16	1.1
Salem	king size, filter, menthol, (hard pack)	17	1.2
Marlboro	100 mm, filter	17	1.1
Benson & Hedges	100 mm, filter, (hard pack)	17	1.1
Old Gold Filters	king size, filter	17	1.2
Marlboro	100 mm, filter, (hard pack)	17	1.1
Saratoga	120 mm, filter, (hard pack)	17	1.1
Galaxy	king size, filter	17	1.1
Benson & Hedges	100 mm, filter	17	1.1
Montclair	king size, filter, menthol	17	1.2
Newport	king size, filter, menthol	17	1.2

[1] TPM dry (tar) - milligrams total particulate matter less nicotine and water

Tar[1] and Nicotine Content of One-hundred seventy-six (176) Varieties of Domestic Cigarettes (shown in increasing order of tar values)

BRAND	TYPE	Tar (mg/cig)	Nicotine (mg/cig)
Benson & Hedges	100 mm, filter, menthol	17	1.1
Marlboro	king size, filter	17	1.1
Marlboro	king size, filter, (hard pack)	17	1.1
Lark	king size, filter	17	1.2
Long Johns	120 mm, filter	17	1.3
Max	120 mm, filter	18	1.4
Benson & Hedges	king size, filter, (hard pack)	18	1.4
Winston 100's	100 mm, filter	18	1.3
Max	120 mm, filter, menthol	18	1.4
Pall Mall	100 mm, filter	18	1.3
Philip Morris International	100 mm, filter, (hard pack)	18	1.1
Philip Morris International	100 mm, filter, menthol, (hard pack)	18	1.1
Tall	120 mm, filter	18	1.5
Pall Mall	king size, filter	19	1.2
Camel	king size, filter	19	1.4
Old Gold 100's	100 mm, filter	19	1.4
Kool	reg. size, non-filter, menthol	19	1.1
Winston	100 mm, filter, menthol	19	1.4
Lark	100 mm, filter	19	1.3
Winston	king size, filter, (hard pack)	19	1.4
Spring 100's	100 mm, filter, menthol	19	1.1
Salem	100 mm, filter, menthol	20	1.5
Winston	king size, filter	20	1.4
Newport	100 mm, filter, menthol	20	1.5
Philip Morris	reg. size, non-filter	21	1.3
Picayune	reg. size, non-filter	23	1.4
Chesterfield	reg. size, non-filter	23	1.4
Piedmont	reg. size, non-filter	23	1.3
English Ovals	reg. size, non-filter, (hard pack)	23	1.8
More	120 mm, filter	23	1.8
More	120 mm, filter, menthol	24	1.8
Lucky Strike	reg. size, non-filter	24	1.4
Home Run	reg. size, non-filter	24	1.5
Raleigh	king size, non-filter	24	1.3
Pall Mall	king size, non-filter	24	1.4
Half & Half	king size, filter	24	1.8
Old Gold Straights	king size, non-filter	25	1.6
Players	reg. size, non-filter, (hard pack)	26	1.9
Camel	reg. size, non-filter	26	1.8
Philip Morris Commander	king size, non-filter	27	1.7
Chesterfield	king size, non-filter	28	1.7
Herbert Tareyton	king size, non-filter	28	1.7
Fatima	king size, non-filter	28	1.6
Bull Durham	king size, filter	28	1.9
English Ovals	king size, non-filter, (hard pack)	30	2.4

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[1] TPM dry (tar) - milligrams total particulate matter less nicotine and water

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AMERICAN CANCER SOCIETY
NEW YORK STATE DIVISION, INC.

RESEARCH
EDUCATION
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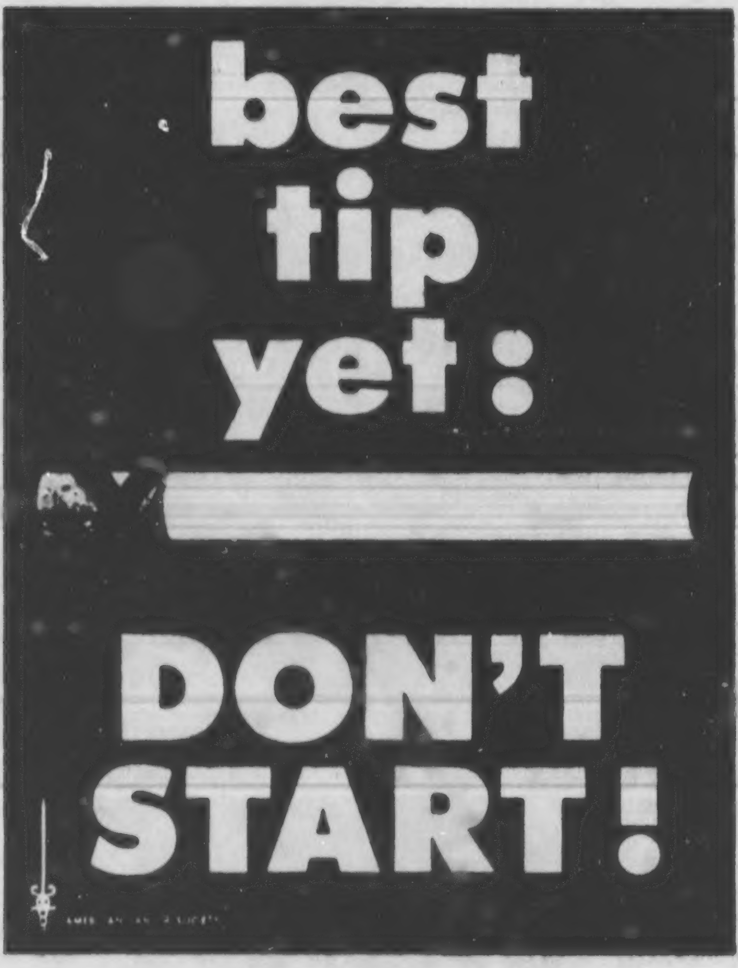
best
tip
yet:
DON'T
START!

SMOKING EXPERIMENTS FOR SCHOOL SCIENCE CLASSES

TO THE TEACHER:

THE SUGGESTED LEARNING ACTIVITIES AND EXPERIMENTS IN THIS PUBLICATION VARY BOTH IN COMPLEXITY AND CONCEPT. SOME PROCEDURES ARE SUITABLE FOR ELEMENTARY SCHOOL CLASSES, WHILE OTHERS ARE MORE APPLICABLE TO HIGHER GRADE LEVELS. EACH TEACHER MUST, THEREFORE, ASSUME RESPONSIBILITY FOR SELECTING THE ONES THAT WILL BE MOST SUITABLE AND PROFITABLE FOR THE PUPILS.

THE EXPERIMENTS WITH LIVING THINGS SHOULD BE INTERPRETED WITH CAUTION. RESULTS OBTAINED WITH OTHER ORGANISMS ARE NOT NECESSARILY APPLICABLE TO HUMANS, BUT ARE DESIGNED TO STIMULATE INTEREST AND TO LEAD TO FURTHER DISCUSSION.

ACKNOWLEDGEMENTS

The American Cancer Society, New York State Division, Inc., acknowledges with thanks the portions of this publication that were reprinted from the New York City Division and Connecticut Division of the American Cancer Society and Roswell Park Memorial Institute, Buffalo, New York.

EXPERIMENT # 1

Purpose:

To demonstrate the tars that are inhaled into the mouth and lungs of a cigarette smoker. Of particular interest will be the difference in the amounts of tar in the inhaled smoke and in that smoke which is exhaled.

Needed Equipment:

1 white handkerchief
1 smoker

Procedure:

Have the smoker inhale from a lighted cigarette, making every attempt to hold the smoke just in his mouth without allowing it to go into the lungs. As rapidly as possible, after inhaling from the cigarette, place a handkerchief over the mouth stretched as firmly as possible and blow the smoke back through the handkerchief. You will note that this will cause quite a dark stain on the handkerchief. Now have the candidate inhale once more from the cigarette only this time allowing the smoke to go well into the lungs. Now again, place a different area of the handkerchief firmly over the mouth and exhale back through the handkerchief. It will be noted that the second stain is much lighter than the first stain. Theoretically, the difference between the two stains represents the amount of tar that remains in the lungs with each puff of the cigarette. The harmful effects and cancer producing properties of these tars are well known.

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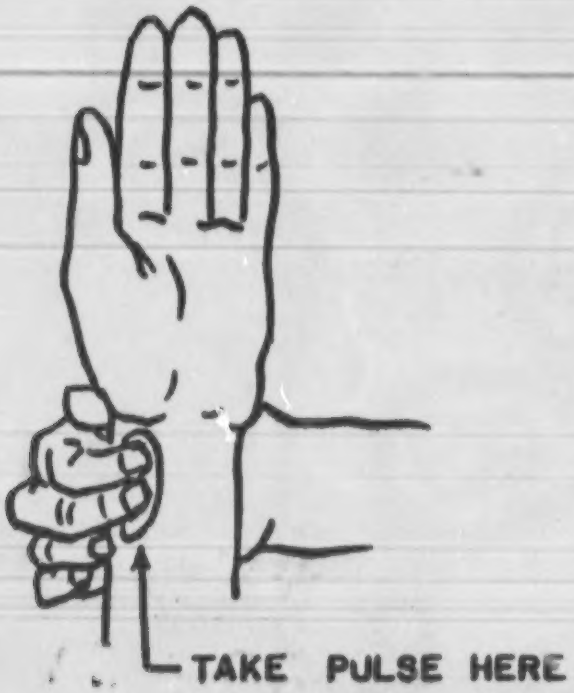
EXPERIMENT # 2

Purpose:

To demonstrate the affect that smoking has upon the heart rate.

Needed Equipment:

1 wrist watch
1 smoker
cigarettes



Procedure:

It is recommended that students do this experiment on their parents at home and record their findings. The arterial pulse, taken at the wrist, is an accurate indication of the heart rate. One can take the pulse of his patient by placing two middle fingers of the right hand on the thumb side of the wrist of the patient (see diagram). The patient's pulse should be taken two or three times to establish a base line accuracy. In each instance, record your pulse rate... as the number of pulsations felt per minute. Have your patient light a cigarette, then take the pulse as he has concluded the 3rd or 4th puff. When the cigarette is finished, take the pulse every fifteen minutes until the pulse rate returns to normal. Chart your findings on a graph and determine how many extra heart beats one pack of cigarettes causes the patient. Since with each beat the heart pumps approximately 70 cc of blood, calculate the extra volume of blood that is pumped by the heart induced by smoking one package of cigarettes. The apparent conclusion is that smoking puts an extra unnecessary load upon the heart and such a burden will, in the long run, shorten life.

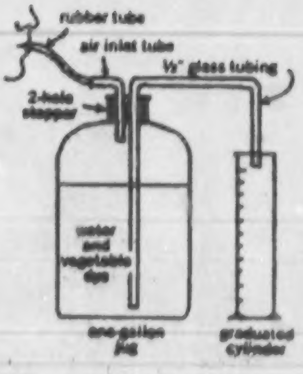
EXPERIMENT # 3

Purpose:

Measuring lung capacity.

Needed Equipment:

one gallon, clear glass, "cider" jug
large graduated cylinder
two hole stopper
1/2" diameter glass tubing
rubber tubing
vegetable dye
water


rubber tube
air inlet tube
½" glass tubing
2-hole stopper
water and vegetable dye
one-gallon jug
graduated cylinder

Procedure:

The bottle is filled with water colored with vegetable dye. A long bent tube extends through the stopper and well below the water level. The other end of the tube is over the mouth of the graduated cylinder. The subject blows through a rubber tube attached to a short piece of glass tubing that passes through the stopper. The pressure of his breath forces water out of the jug into the graduate.

The volume of water displaced each time the subject exhales is a measure of the amount of air displaced from his lungs. By use of a long rubber tube, you can compare the change in volume while the subject is at rest with the changes when he is running in place or doing other physical or mental tasks.

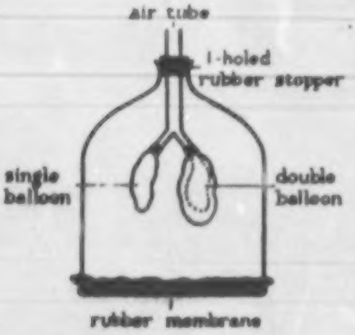
EXPERIMENT # 4

Purpose:

To demonstrate some of the effects of emphysema.

Needed Equipment:

bell jar with rubber membrane
one-hole rubber stopper
three rubber balloons
Y-tube



Procedure:

Obtain several new balloons of similar size and elasticity. Blow up one balloon and allow it to remain inflated for a day or so. When ready for the demonstration, deflate the balloon and note that it does not reduce to its original size. Why? Insert one of the unused balloons into the used one and note the air pocket between the two.

Set up the bell-jar apparatus as shown with the double balloon attached to the other arm, to simulate two lungs. Tie a rubber membrane across the bottom of the bell jar to simulate a diaphragm. Pull down on the rubber membrane and observe the balloons fill with air. Note that the balloon has an air pocket which interferes with its inflation. Push the rubber membrane up into the jar and observe the difference in the deflation of the "lungs."

The action of filling and emptying the balloons may be compared to respiration; if both lungs are functioning properly, they inflate and deflate properly. But if the alveoli of the lungs have been stretched too thin, air pockets form in the lung tissue. The contractile power of the lungs is destroyed.

Why is the "barrel chest" a characteristic of "emphysema?

EXPERIMENT # 5

Purpose:

To demonstrate the relationship between the heart and lungs and the general functioning of the human body.

Needed Equipment:

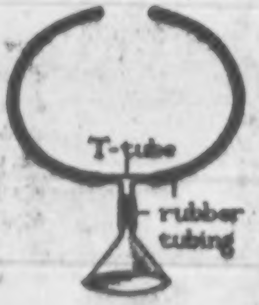
Stethoscope
- rubber tubing
- T-tube
- funnel

Bell-jar apparatus
- bell jar with rubber membrane
- two rubber balloons
- Y-tube
- one-hole rubber stopper
- rubber tubing
- clamp

Procedure:

A. Make a "stethoscope" and have pupils use it to listen to the heart beat. A very satisfactory demonstration stethoscope can be made from a small funnel, a glass T-tube or Y-tube, and some rubber tubing. Slip a piece of rubber tubing approximately 3 inches long over the tip of the funnel. Insert the T- or Y-tube into the other end of the short piece of rubber tubing and attach longer pieces of tubing to both arms of the T- or Y-tube.

To use the stethoscope, have one pupil hold the funnel firmly over his heart while another holds the ends of the long tubes in his ears. Heart sounds will be heard very clearly, though, of course, pupils will not be able to interpret them.



B. Demonstrate the proper method of determining the pulse rate. (Place two fingers on the inside of the wrist and apply slight pressure by pushing against the back of the wrist with the thumb.) Ask pupils to practice finding the pulse rate and have pupils count pulse for 1 minute, 30 seconds, and 15 second periods.

Ask pupils to check their own pulse rates at rest and after a given amount of physical exercise. Discuss the difference in the rate and implications for the work of the heart and lungs.

C. Set up the bell-jar apparatus as shown:

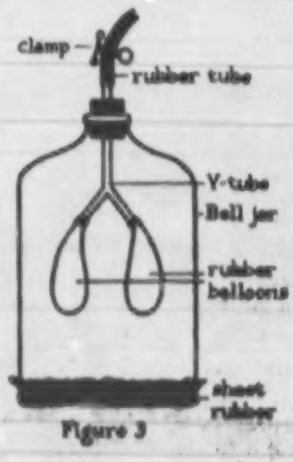

clamp
rubber tube
Y-tube
Bell jar
rubber
balloons
sheet
rubber

Figure 3

The balloons simulate the two lungs, the glass jar, the bony girdle, and the rubber membrane, the diaphragm. Pull down on the rubber membrane and observe the balloons fill with air; push the membrane up into the jar and observe the action of the balloons. The action of filling and emptying the balloons may be compared to respiration. If both lungs are functioning normally they inflate and deflate properly.

EXPERIMENT # 6

Purpose:

To demonstrate the effects of tobacco on the human body.

Needed Equipment:

cigarettes
thermometer
thermocouple
watch
sphygmomanometer
spirometer
tremor apparatus

Procedure:

To emphasize the effects of tobacco on a human body, whether it be a filtered or plain cigarette, the following experiments are recommended.

First you need volunteers who smoke two, four or as many cigarettes as you wish. These volunteers should be equally divided as to sex and examined in the following areas before smoking.

1. Temperature
   Oral temperature should be taken of each volunteer for three minutes. If possible to obtain a thermocouple, temperature of hands and feet should be taken.

2. Pulse
   The pulse should be taken at least three times for an accurate count.

3. Blood Pressure
   Systolic and diastolic pressure is taken with a sphygmomanometer. Instructions for operation of such an instrument may be found in any physiology text.

   If a sphygmomanometer is not available in the science department, contact your school physician for the availability of such an instrument.

4. Vital Capacity
   The maximum volume of air which the lungs can exchange during a single respiration represents a person's vital capacity. To measure a person's vital capacity, you need a spirometer. To operate this type instrument is relatively easy: all you do is instruct your volunteer to take the deepest breath possible and blow into the glass tubing until he or she exhausted all the air in one breath. By reading the measure on the elevated container, one obtains the volume of the person's vital capacity.

5. Tremors
   With a tremor apparatus one can measure neuromuscular coordination. Often a person hears how smoking steadies the nerves. To investigate the truth of such a statement the tremor test was devised.

   After these tests are completed and statistics recorded, you permit the group chosen to smoke. Twenty minutes later you conduct the same five tests over again, record and compare the results.

The following chart is a typical example of the experiments:

Typical Average Results of Smoking Experiment

HIGH SCHOOL SOPHOMORES

	Before Smoking		*After Smoking (20 Minutes Later)*	
	Male	*Female*	*Male*	*Female*
Temp.	98.3°	98.6°	98.9°	98.7°
Pulse	85.8/min.	86./min.	105./min.	97.6/min.
Blood Pressure	$\frac{112.8}{70.8}$	$\frac{110.8}{68.8}$	$\frac{119.6}{69.2}$	$\frac{116.8}{66.4}$
Vital Capacity	4332 c.c.	3076 c.c.	3864 c.c.	2664 c.c.
Tremors	$\frac{4.8 \text{ in.}}{16}$	$\frac{4.9 \text{ in.}}{16}$	$\frac{5.3 \text{ in.}}{16}$	$\frac{5.1 \text{ in.}}{16}$
Saliva	Medium	Moist	Moist	Moist

SPIROMETER

Materials Needed:

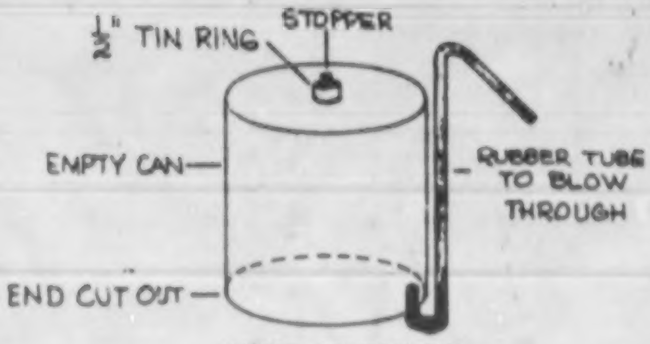
- five quart oil can
- one can slightly larger than five quart oil can
- one rubber stopper to fit 1/2" opening
- solder and soldering iron
- three to four feet of rubber tubing
- one four-inch piece of glass tubing
- copper wire
- can opener

Procedure:

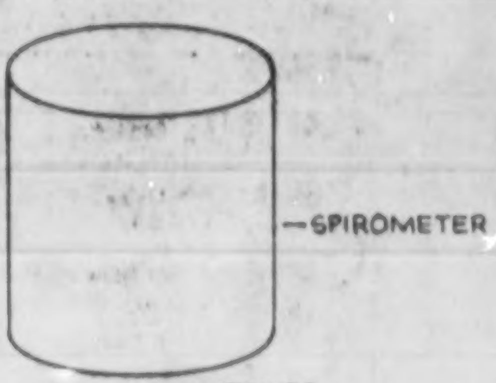
One end of a five-quart oil can is cut out and on the inside small wires are soldered to the sides of the can to hold the hose. On the other end of the can a half inch hole is cut and a small tube is soldered out of tin and fitted with a stopper. This allows the air to escape when submerging the can in the larger can of water. Marks on the outside of the five-gallon oil container can be calibrated accurately with the use of a liter graduated cylinder.

The rubber tubing through which one blows should be fitted with glass tubing and the ends fire polished.

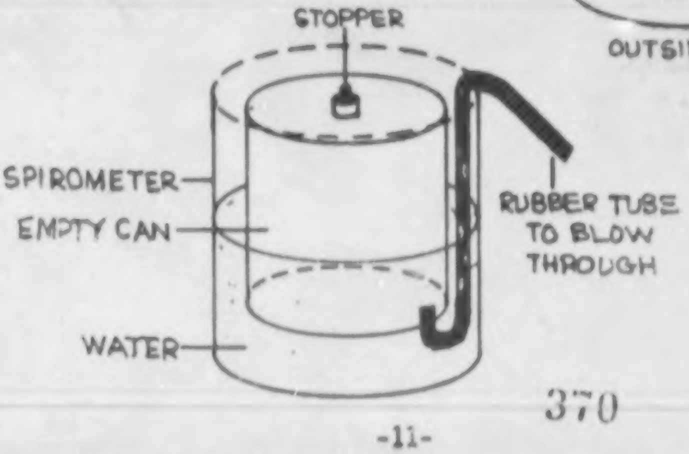
After a student uses the spirometer the glass tube should be placed into 70% alcohol solution for antiseptic purposes.


½" TIN RING
STOPPER
EMPTY CAN
RUBBER TUBE TO BLOW THROUGH
END CUT OUT

INSIDE CONTAINER


SPIROMETER

OUTSIDE CONTAINER


STOPPER
SPIROMETER
EMPTY CAN
RUBBER TUBE TO BLOW THROUGH
WATER

TREMOR APPARATUS

Materials Needed:

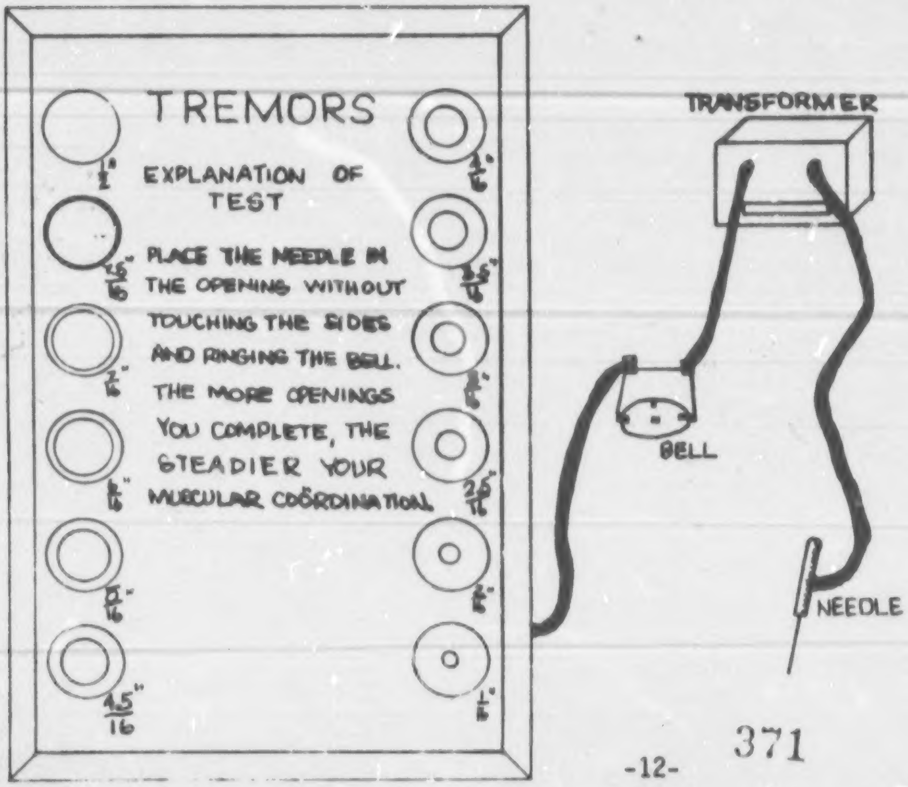
one piece of conduction type metal, 12" x 15"
bell or a buzzer
train transformer or ordinary transformer or two dry cell batteries, 1 1/2 volts each
one straight dissecting needle or an ice pick
nine feet of wire

Procedure:

The metal may be obtained from the high school shop and the holes drilled at the same time. If you are in good standing with the shop teacher you may be able to get fancy by putting a frame around the metal with a stand in the rear. Be nice to him because you'll be back for more help in making a spirometer. Once the metal stand is made, identification of hole openings may be printed or glued under the openings. Explanation of the the tests may be typed or printed on a sheet of white paper and glued on to the metal as indicated in the diagram.

A wire from the bell or buzzer is attached on the metal sheet. It is best to have a small screw soldered on the rear of the metal for such attachment. Another wire from the bell is attached to the transformer or batteries. The batteries should be connected in series first.

That is, you connect the positive pole of one battery with a piece of wire with the negative pole of the other battery. From the other contact point of the transformer or battery you attach the dissecting needle with about four feet of wire.


TREMORS
EXPLANATION OF TEST
PLACE THE NEEDLE IN THE OPENING WITHOUT TOUCHING THE SIDES AND RINGING THE BELL. THE MORE OPENINGS YOU COMPLETE, THE STEADIER YOUR MUSCULAR COÖRDINATION
1/2"
5.5/16"
7/16"
6/16"
5/16"
4.5/16"
4/16"
3.5/16"
3/16"
2.5/16"
2/16"
1/16"
TRANSFORMER
BELL
NEEDLE

$\frac{1}{2}$" TO $\frac{5}{16}$" = POOR
$\frac{1}{2}$" TO $\frac{4.5}{16}$" = FAIR
$\frac{1}{2}$" TO $\frac{3.5}{16}$" = GOOD
$\frac{1}{2}$" TO $\frac{2}{16}$" = VERY GOOD
$\frac{1}{2}$" TO $\frac{1}{16}$" = EXCELLENT

EXPERIMENT # 7

Purpose:

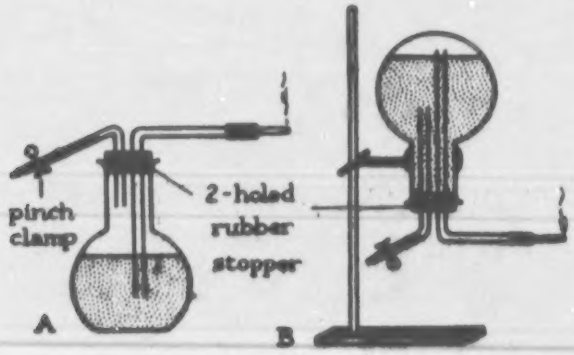
To demonstrate the tars present in the smoke of a cigarette.

Needed Equipment:

flask
two-hole rubber stopper
pinch clamp
stand
water
holding clamp
rubber tubing
glass tubing
cigarettes

Procedure:

Fill a clean flask approximately three-fourths full of water. Close the flask with a two-holed stopper fitted with glass tubes as shown.



Fit a cigarette into one end of a piece of rubber tubing and connect the other end of the rubber tubing to the glass tube as shown in A. Invert the flask as shown in B.

Start the siphon and light the cigarette. The pinch clamp may be used to open or close the siphon at regular intervals to simulate puffing on the cigarette.

Observe the dense smoke which collects above the surface of the water. When the cigarette is almost completely burned remove it, drop it in some water, and then discard it.

Shake the inverted flask to wash the smoke with the water. Note the color that appears in the water. Why?

Empty the flask and note the residue on the inside walls of the flask. "Smoke" several cigarettes in the apparatus to obtain more residue. Is this residue difficult to remove from the flask? From this experiment, what might be deduced concerning the appearance of the lung tissue of persons who smoke? Select class representatives to check the answer with a pathologist.

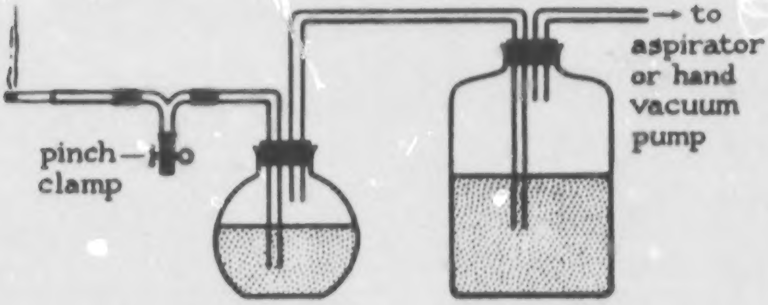
EXPERIMENT # 8

Purpose:

To collect tar residues.

Needed Equipment:

jar
flask
2-hole rubber stopper (two)
pinch clamp
water
rubber tubing
glass tubing
cigarettes
vacuum source



Procedure:

Perform some of the following experiments to demonstrate the effects of tar from cigarette smoke on animal life. (NOTE: Teachers are cautioned not to draw conclusions that humans would be affected in the same ways. Results of the experiments should encourage pupils to study any information they can find regarding the effects of cigarette smoke on human tissue).

Set up smoking apparatus as shown. Collect "tar" in Y-tube. Touch some of the "tar" on the tongue of a frog and note temporary collapse. This illustrates how "tar" acts as a poison. Substitute tadpoles for frog and observe results.

Place a drop of solution containing paramecia on a microscope slide. With the low power of a microscope, observe movement of these one-celled organisms. Blow smoke on the preparation and note the effects on the paramecia.

Use the smoking device as shown and insert small pellets of cotton or strands of glass wool in the straight section of glass tubing between cigarette and Y-tube. (Be sure the cotton does not plug the tube.) Also place loose pellets of cotton or glass wool at all points of Y. Observe if more tar precipitates at the Y-shaped bifurcation. Compare the Y-shaped bifurcation with the structure of the bronchial tree in the lungs of humans. Suggest a possible reason for the more frequent occurrence of lesions at the bifurcations than elsewhere in the bronchial epithelium of heavy cigarette smokers.

EXPERIMENT # 9

Purpose:

To demonstrate the tars present in the smoke of a cigarette. (To discuss whether filters make cigarettes safe to smoke.)

Needed Equipment:

- 1 regular funnel
- 1 buchner funnel
- filter paper
- cigarettes (regular & filter)
- suction flask
- vacuum source
- a single hole rubber stopper

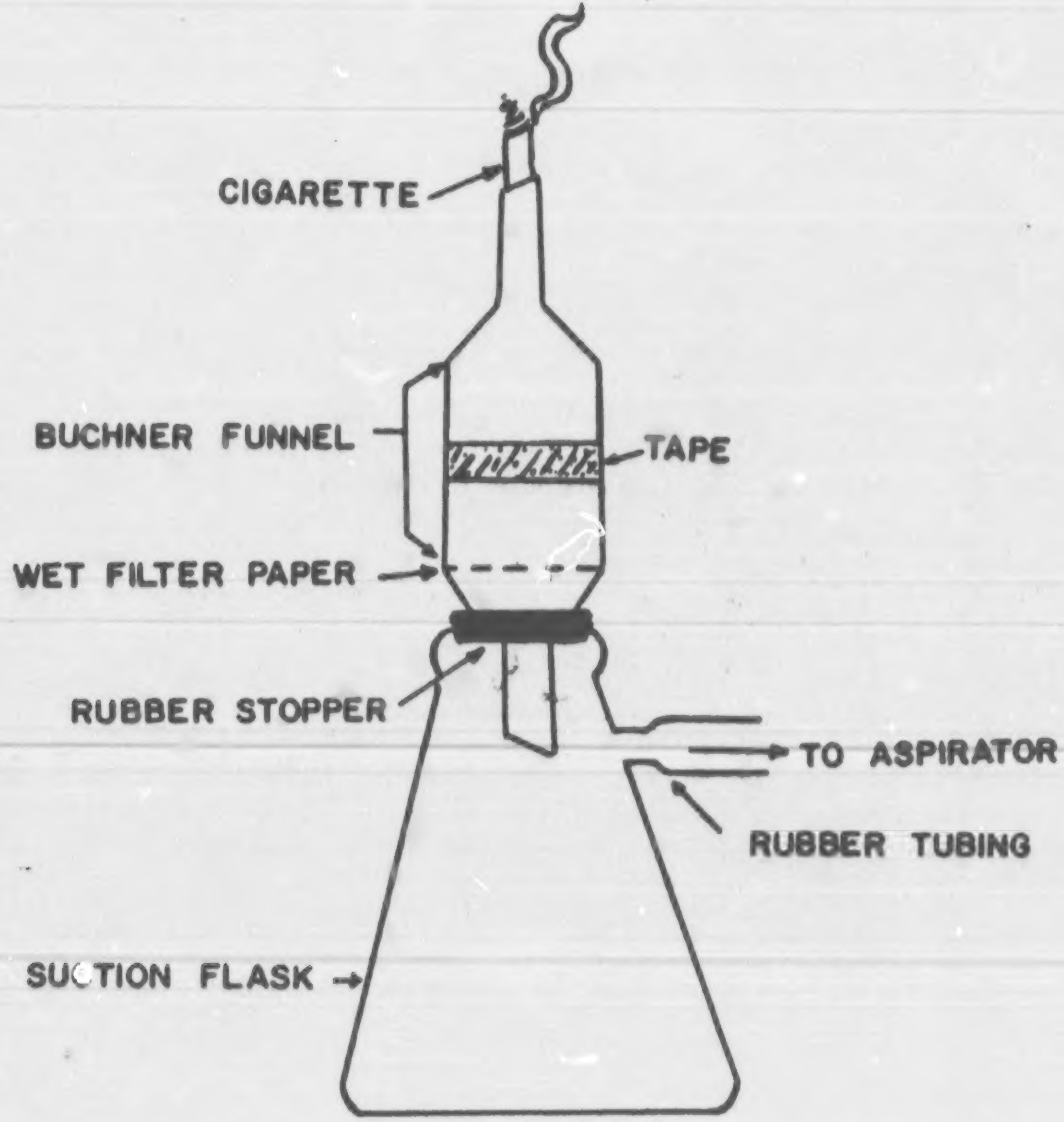
Procedure:

Place a cigarette in the top funnel as indicated in the diagram. Turn on your vacuum source and light the cigarette. The smoke from the cigarette will pass through the funnels and the moistened filter paper into the suction flask. The moistened filter paper will collect a portion of the tar in the smoke, resulting in a dark yellow stain. Some tars that pass through the filter will condense in the moisture in the suction flask and a yellow solution will be noted.

"Smoke" several brands of regular cigarettes and filter cigarettes, changing the filter paper each time. Discuss the difference in the amount of tar residue collected from the different types of cigarettes.

Use several layers of filter paper, also filter papers of different-sized pores. Observe the smoke particles which pass through the filter paper by directing flashlight on the contents of the flask.

With this simple apparatus, one can grossly determine the answer to some interesting questions. Which brand of cigarette leaves the greatest tar residue? Which filter is the most effective in cutting down the amount of tar which is inhaled? Do some cigarette manufacturers use stronger tobacco in their filter cigarettes to compensate for the lack of taste? In conclusion, it is to be noted that the smoke from all types of cigarettes causes cancer in animals under experimental conditions.


CIGARETTE
BUCHNER FUNNEL
TAPE
WET FILTER PAPER
RUBBER STOPPER
TO ASPIRATOR
RUBBER TUBING
SUCTION FLASK

EXPERIMENT # 10

Purpose:

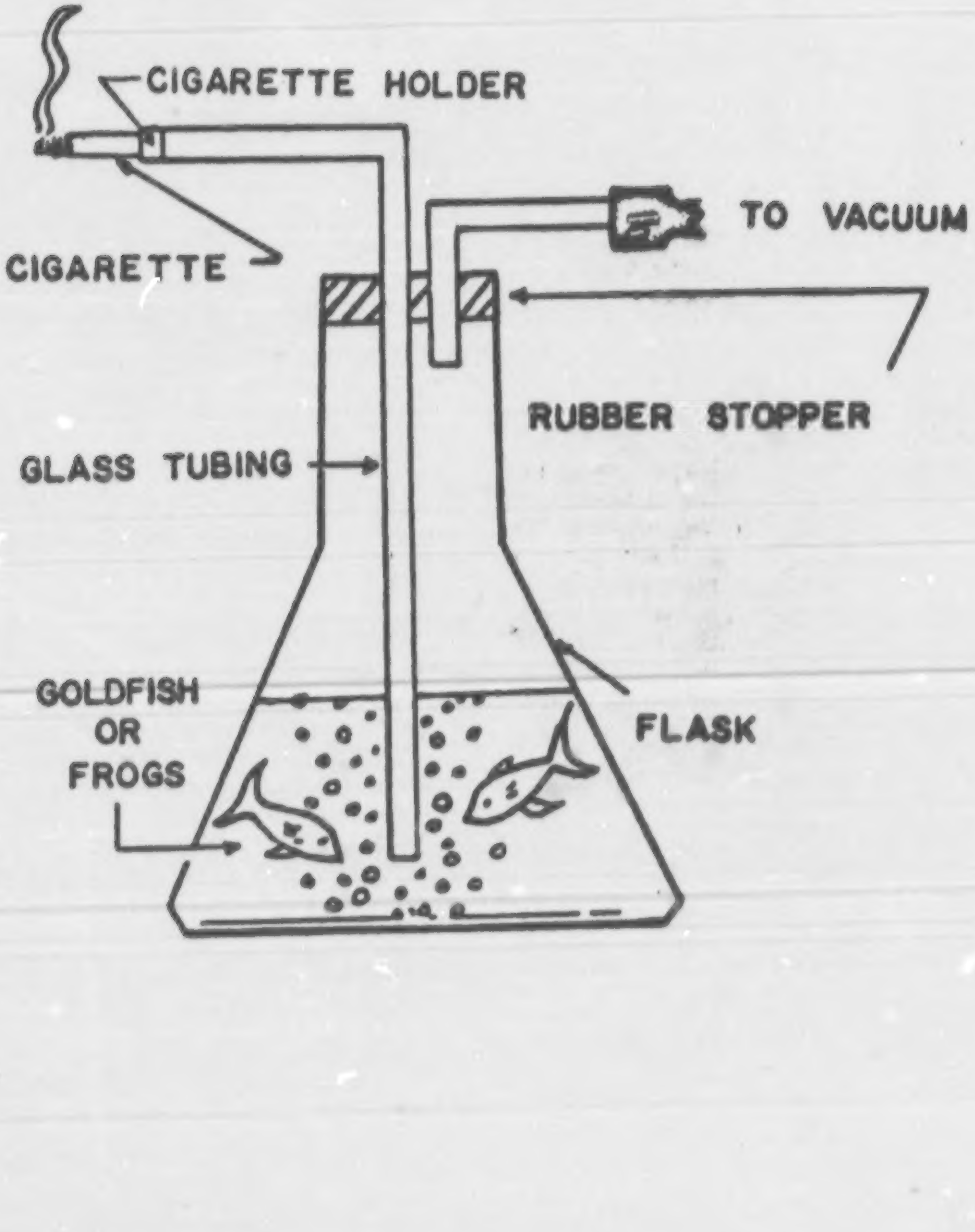
In the smoke delivered from a cigarette there are at least 300 toxic compounds. Most of them are not readily recognized by name, but a few such as lead, arsenic, cyanide, nicotine, formaldehyde, and carbon monoxide are well known. The purpose of this experiment is to demonstrate the effect cigarette smoke can have on fish when they are compelled to absorb the chemicals in cigarette fumes.

Needed Equipment:

2 or 3 goldfish
500 cc flask
glass tubing
cigarettes
water
a vacuum source (siphon or aspirator)
rubber stopper with glass tubing holes

Procedure:

Hook a vacuum line (from an aspirator or siphon) to a burning cigarette in the manner described in the following drawing. As the vacuum is applied, the smoke from the cigarette will bubble through the water. By the time three to ten cigarettes have been consumed, the toxic agents in the smoke, primarily nicotine, should begin to affect the fish causing them to lose their equilibrium. As soon as the fish lose their equilibrium, and begin to roll to one side, they should be removed from the water and placed immediately in fresh water. If this is not done promptly, this experiment will be fatal to the fish.


CIGARETTE HOLDER
TO VACUUM
CIGARETTE
RUBBER STOPPER
GLASS TUBING
GOLDFISH
OR
FROGS
FLASK

EXPERIMENT # 11

Purpose:

Collecting tobacco tars from cigarettes and conducting biological studies.

Needed Equipment:

6 - 10 white mice
aspirator or water pump
flask, beaker, or bottle
acetone
electric clippers
eye dropper
rubber tubing
stopper with glass tubing holes
glass tubing
glass wool
cigarettes

Procedure:

Hook a vacuum line (from an aspirator or water pump) to a burning cigarette in such a manner that the cigarette is consumed in about 4-6 minutes. (Several glass tubes fitted with cigarettes can be smoked simultaneously depending upon the number of holes made in the rubber stopper.) In the line, a trap containing glass wool moistened with acetone should be attached. This will collect most of the tobacco tars. See diagram. The distillation of the tar can be facilitated by placing the bottle in an ice water bath during the course of the experiment.

After the cigarettes (about 40 cigarettes per day) have been smoked, the tar can be removed with additional acetone - using as little as possible to dissolve the tar. This solution should be allowed to stand for several hours in a fume hood to concentrate the tar. A vacuum distillation method in a warm water bath without flame is effective.

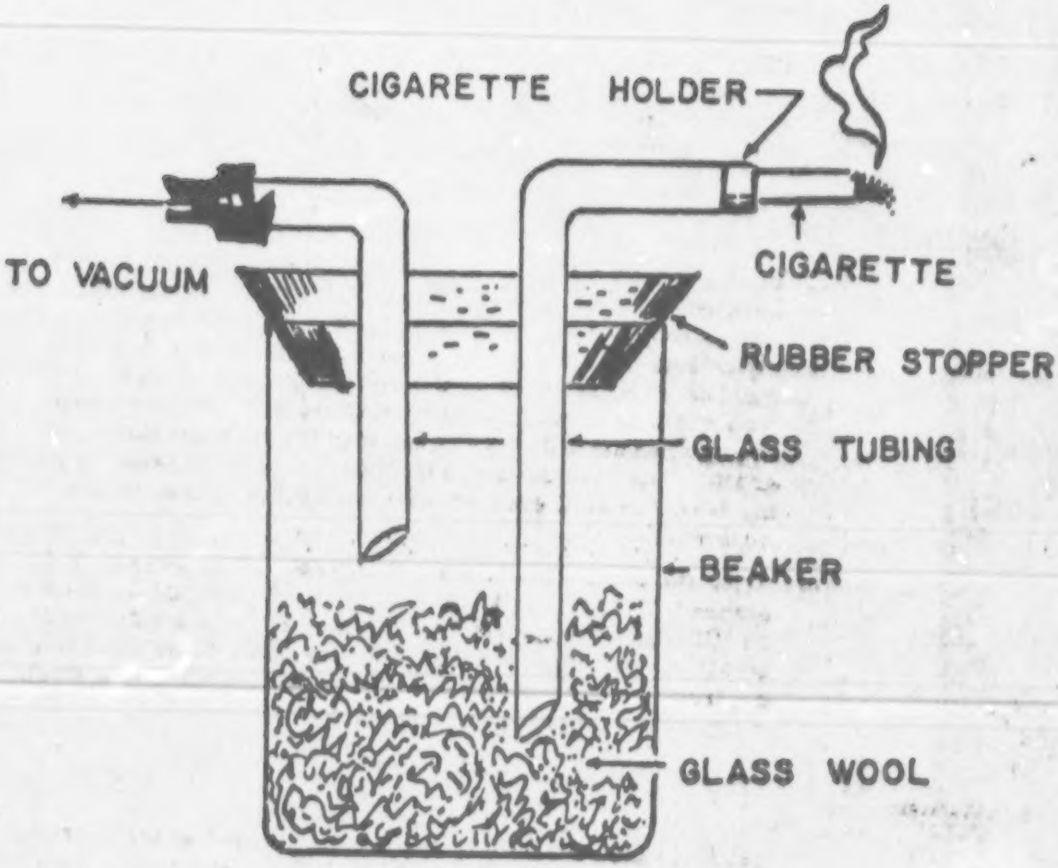
Caution:

Students conducting this experiment should at all times be under the close supervision of a science instructor. Acetone is flammable and tobacco tars are toxic.

Biological Study:

The backs of mice should be trimmed with electric clippers to remove heavy hair growth. The tars from about three cigarettes can be applied by eye dropper twice daily to the clipped area, five days a week.

Tumors can be expected to appear in about 40% of the mice in 6 to 9 months. These will be both benign and malignant tumors.


CIGARETTE HOLDER
TO VACUUM
CIGARETTE
RUBBER STOPPER
GLASS TUBING
BEAKER
GLASS WOOL

TEACHER DEMONSTRATION # 1

Purpose:

To demonstrate the effects of smoking on cardiovascular disease.

Procedure:

A. Wrap the body of a frog with a wet cloth, put him on his back on a frog board, strap him gently with tape to the board, then spread and pin the web of one foot over an opening in the board. Adjust the web under low power of a microscope so that several blood vessels are visible and the blood flow may be observed. Note the speed of flow. Keep preparation moist with Ringer's solution. Fill a plastic bottle with cigarette smoke from a smoking device. This may be accomplished by filling the plastic bottle with smoke by upward displacement of air as follows: Remove the plastic top with attached plastic tube from bottle, remove cigarette from tube of smoking device, insert tube well down into plastic bottle, reverse the water flow in the siphon (by connecting siphon tube to a water inlet) to displace smoke by water. Fill plastic bottle with smoke, and cover promptly with plastic top with tube insert.

Administer smoke to the frog by inserting the tube into his mouth and squeezing the bottle. Note the change in rate of blood flow. Usually, there is an increase followed by a decrease and a return to normal. Occasionally there may be a second decrease followed by a return to normal rate.

If there is difficulty in keeping the blood vessels of the web in focus because of the activity of the frog, pith the frog and then proceed with the experiment.

Questions:

What conclusions may be drawn as to the effects of cigarette smoke on the peripheral circulation of the frog?

Are there possible harmful aspects to altering the rate of blood flow in an animal?

In experiments with humans, what effect has cigarette smoking been shown to have on the circulatory system?

What changes may be expected in the cirulatory system of a person who smokes 20 to 40 cigarettes a day?

B. Narcotize a salamander by soaking him in a one to ten dilution of water-saturated solution of chloretone until it stops wiggling. Then remove the salamander from the solution and lay him on his back. If he cannot right himself, he is sufficiently narcotized.

Dip cotton in the soaking solution and hold against the salamander's skin at anytime during the experiment when he appears to be reviving. Open the chest and abdominal cavity. Move a lung gently to one side, being careful not to cut off the blood flow. Put the lung over a hole in the cork board. Keep lung wet with Ringer's solution. Use the low power of a microscope to observe the blood flow in the lung and note the speed of flow. Blow one puff of cigarette smoke, from a smoking device, on the lung preparation and note the change in speed of flow.

Have volunteers review research reports to determine the effect of smoking on the speed of blood circulation. What effects might be expected on the circulation of a person who smokes 20 to 40 cigarettes a day.

TEACHER DEMONSTRATION # 2

Purpose:

To demonstrate the effect of smoking on the lungs.

Procedure:

A. Narcotize a salamander by soaking him in a one to ten dilution of water-saturated solution of chloretone. Decapitate the salamander and open the chest and abdominal cavity. Snip off a lung and slit it longitudinally. (It may be easier to slit the lung before snipping it off.) Lay the lung flat, cut side up, over a hole in a cork board or place on microscope slide. Keep the preparation wet with Ringer's solution.

Using the low or high power of a microscope, observe the cilia beating. Blow one puff of cigarette smoke from a smoking device on the lung and note the effect on the cilia.

Review research to determine the effect of cigarette smoking on cilia in the respiratory tract of smokers who inhale.

B. Set up a microscope and make available for study slides that are made with tissue taken from the lungs of cigarette smokers, non-smokers, and ex-smokers. These slides should be secured by the teacher through the school physician or school nurse who in turn can borrow them from a pathologist.

TEACHER DEMONSTRATION # 3

Purpose:

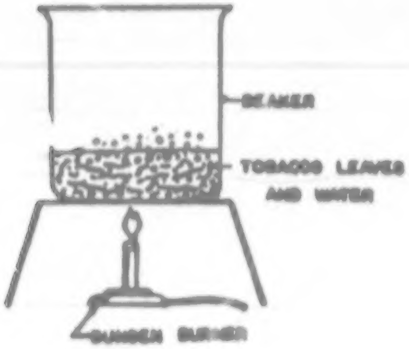
To demonstrate the poisonous agents that are present in tobacco leaves.

Needed Equipment:

- 1 or 2 white mice
- water
- tripod
- cigarette
- bunsen burner
- small syringe
- 27 gauge needle
- 100 cc beaker
- filter paper

Procedure:

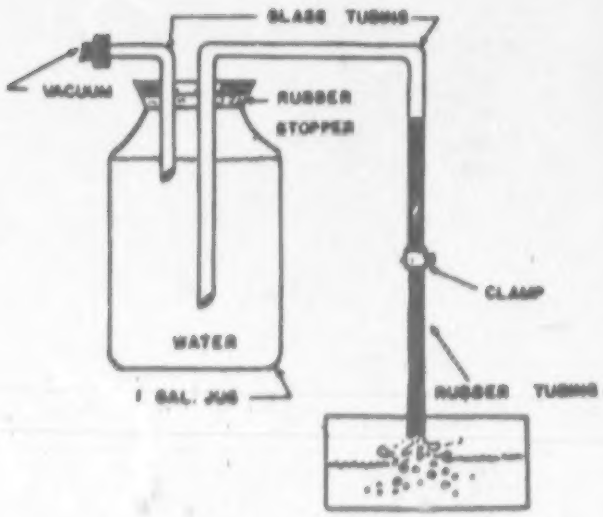
Place 10 cc of water into the 100 cc beaker. Bring the water temperature to the boiling point and maintain the temperature at a slow boiling heat. Take the tobacco from one cigarette and add to the boiling water. Stir slowly at constant heat for five minutes. Turn off the bunsen burner and allow the solution to pass through standard laboratory filter paper into a clean beaker. Allow the solution to cool. Draw between 1/4 and 1/2 cc of the filtered solution into the syringe. Now as you examine your mouse, you will find that the veins of the tail are quite prominent as light blue streaks. Insert the needle of your syringe into the vein and inject 1/4 to 1/2 cc of the filtered solution. Within a minute, the animal will enter a convulsing state, which in most instances will lead to death. While the nicotine in one cigarette is sufficient enough to kill many mice, there is enough nicotine in a cigar to kill two men.



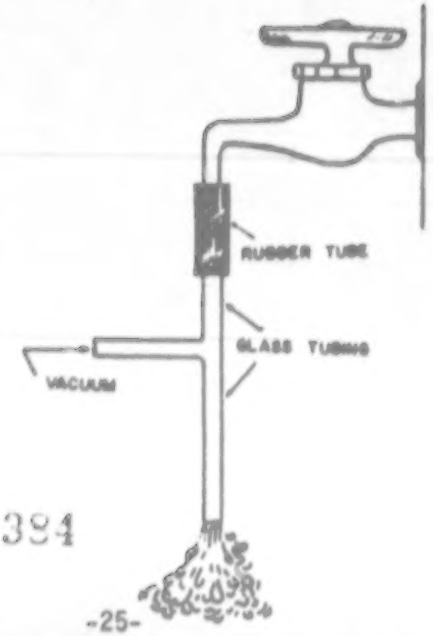
APPENDIX:

In several of the experiments included in this curriculum, a vacuum source is essential. Four simple methods of obtaining a vacuum are as follows:

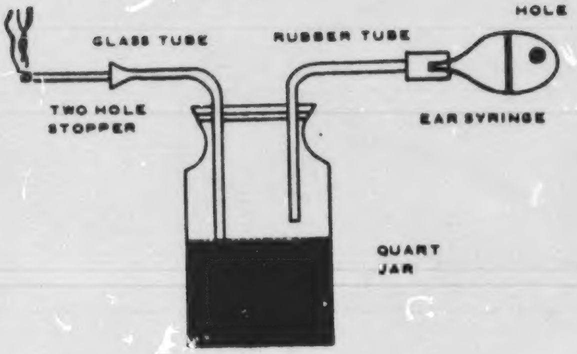
1. Siphon


GLASS TUBING
VACUUM
RUBBER STOPPER
CLAMP
WATER
1 GAL. JUG
RUBBER TUBING

2. Aspirator


RUBBER TUBE
GLASS TUBING
VACUUM

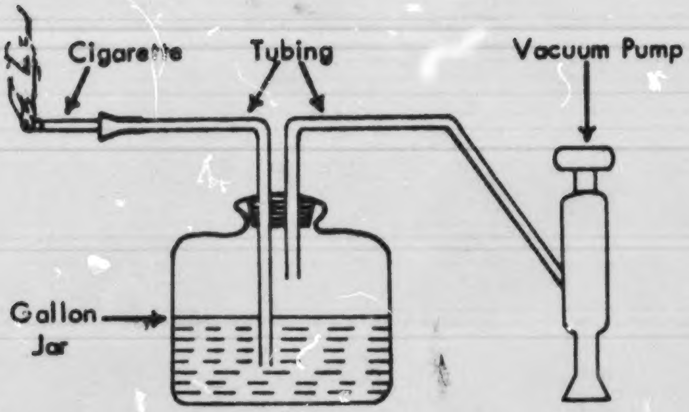
3.


GLASS TUBE
RUBBER TUBE
HOLE
TWO HOLE STOPPER
EAR SYRINGE
QUART JAR

Squeeze syringe slowly and air goes out of its hole (watch to see that water is not forced up the tube with the cigarette.)

Release and cover hole with finger and the vacuum formed as the syringe returns to shape will activate the cigarette. Repeat until cigarette is consumed.

4.


Cigarette
Tubing
Vacuum Pump
Gallon Jar

HO-35

BIOFEEDBACK INSTRUCTIONS FOR STUDENTS

3 subjects with every test:
1 smoker - smokes one cigarette
1 second hand smoker - in the same room as smoker
1 control (instructor) - no contact with smoke before or after test

I. Equipment:

Carbon Monoxide Ecolyzer - measures carbon monoxide in exhaled air in ppm.

Instructions:

1. Have individual breathe in normally, exhale normally and then fill up air bag with the air left in the lungs.
2. Turn machine knob to "ON".
3. Attach air bag to filter (which is attached to intake port).
4. Make sure "range" is on "low". If the needle goes beyond 50 p.p.m., switch to "high".
5. Read the bottom scale (if range is on "low") and record data. Turn off machine at once.

*This is a very sensitive instrument. Turn machine to "OFF" as soon as there is a constant needle reading. Make sure machine is off before the air bag is empty.

Cardio-Tach - measures heart rate in beats per minute.

1. Place the finger probe into "sensor/charger" port & screw until finger tight.
2. Place middle finger of left hand of subject into the sensor clamp. Make sure the finger is all the way to the back of the clamp.
3. Turn machine "ON". Keep the volume low. After watching the digital readout for about a minute, estimate what the average # beats per minute is. It may take longer than a minute.
4. The subject must remain still and the hand should remain stationary on a table.
5. Record data and turn off machine.

Cyborg Thermometer: measures skin temperature at the fingertip.

1. Attach insulated probe to input port on the left of the instrument.
2. Place the probe end (small rounded white end) to the finger print of the subject's finger. Secure the probe by wrapping the blue band loosely around the finger.
3. Turn "mode" switch to F^0 (Fahrenheit)
4. The subject's temperature will read out digitally on the left side.

tens	ones	tenths	hundreths
7	1.	4	0123456789

5. The temperature will read out as specifically as the hundreths. A light behind the number on the hundreths scale will show what the temperature is to the hundreths. Do not take a temperature reading until this light has become constant or only fluctuates slightly.
6. It is important to have the subject keep the hand steady & at the same level as the pre-test.

7. Turn off the instrument and record data.
8. Disconnect the subject from the instrument.

Tremor Testor: measures hand steadiness.

1. Turn calculator to "on" using switch on the right side of the instrument.
2. Take probe out of probe return and hand to subject.
3. Press buttons on calculator in following order:
   a. Clear
   b. Set
   c. Run
4. Have subject very slowly insert probe into the smallest hole on the left of the calculator. Have them place it very slowly in; then very slowly out. Repeat as necessary until time limit is up. Test the subject for a 20 second time span, moving the probe in and out of the hole the entire time.
5. Turn off machine, return probe to "probe return" and record data.

II. Blood Pressure Blood Pressure Measurement Technique

A. A stethoscope and a blood pressure cuff are used in the measurement of blood pressure. (The ear pieces of the sphygmomanometers may be cleaned with alcohol after use.)

1. Have the patient sit with his arm level with the heart. Roll up the sleeve if necessary, but do not cut off circulation to the arm. Do not take blood pressure through a sleeve.
2. Feel for the brachial pulse. Using three fingers, press firmly against the inner aspect of the elbow.
3. Squeeze all the air out of the blood pressure cuff. Wrap the cuff around the upper arm, 1-2 inches above the brachial pulse. The patch on the cuff should be facing forward with the appropriate arrow (left or right) lined up with the brachial pulse.
4. Find the radial pulse at the wrist. Inflate the cuff by pumping the bulb and observe the dial, note when the pulse can no longer be felt. Let the air all the way out of the cuff.
5. Wait at least 30 seconds, then inflate cuff to 30 mm Hg above the pressure where the raidal pulse disappeared. Place the stethoscope in the ears with the ear pieces pointing away from you. This blocks out noise and is more comfortable.
6. Place the diaphragm of the stethoscope over the brachial arthery. Inflate the cuff by pumping the bulb. Pump quickly.
7. Loosen the wheel by turning to the left. This will let the air out of the cuff. The blood pressure should drop 2 mm Hg for each heart beat heard through the stethoscope.
8. Listen for a tapping sound of the heart beat. When the tapping sound begins, note the number of the gauge. This is the systolic blood pressure. Continue to release air from the duff. When the tapping sound stops completely, note the number on the gauge. This is the diastolic pressure.

Tapping starts = Systolic pressure
Tapping stops = Diastolic pressure

9. Let remaining air out of the cuff.

B. What is Happening?

As the cuff tightens around the arm, it squeezes the brachial artery and eventually stops the flow of blood. As air is released, the pressure from the cuff is less than the pressure of the blood; the flow of blood will begin again. The tapping sound is the surge of blood with each heartbeat. It marks the systolic blood pressure. As air is let out of the cuff, the pressure on the artery continues to fall. When the pressure from the cuff is less than the pressure of blood flow, the tapping sound will stop. This is the diastolic blood pressure.

C. Points to note:

1. Do not overinflate the cuff!
2. If you hear tapping as soon as you begin taking the pressure, let the air all the way out of the bag, wait for a few minutes, then begin again by taking the radial pulse and adding 30 mm Hg.
3. If it is difficult to hear the pulse, deflate the cuff and have the "patient" hold their arm over their head and open and close their fist. Then quickly pump up the duff, lower the arm, and try again.
4. If a reading is elevated, let the air all the way out of the cuff, wait at least 2 minutes, and take the measurement again. Repeat a second time if necessary. If this third reading is also elevated, refer the "patient" to a qualified health professional.

III. Experiment:

Pre-test:

1. Test all individuals before they start the experiment and record the data from each piece of equipment including blood pressure.
2. Have two subjects go into the smoking room and have the smoker smoke a cigarette while the non-smoker (second hand smoker) sits close to him/her.
3. Have them stay in the room for 7-10 minutes mimimum.
4. While in the smoking room, have the subjects complete the survey form.

Post-test:

1. Retest all individuals immediately after they return from the smoking room.
2. Retest them on the machine in the following order:
   a. Carbon Monoxide Ecolyzer
   b. Cardio-Tach
   c. Thermometer
   d. Tremor
3. Make sure that you are recording the data and noting the time that the reading is taken.

Biofeedback Smoking Project

Instructors/Controls-non-smokers to work equipment or serve as controls.

Name	Period Free

Client/Subjects-must agree not to smoke for 24 hrs prior to test - Must Get Permission Slip Signed.

Name	Period Free

DATA COLLECTION SHEET FOR BIOFEEDBACK SMOKING PROJECT

SUBJECT'S NAME: ____________________

AGE: ________

SEX: ____M ____F

ROLE: ____SMOKER ____NONSMOKER ____CONTROL

HOW LONG HAS SUBJECT BEEN A SMOKER: ____________

INSTRUCTOR'S NAME: ____________________

SCHOOL: ____________________

SUPERVISING TEACHER: ____________________

DATE: ____________________

WHAT BRAND: ____________________

	Clock Time	Carbon Monoxide Ecolyzer-parts/million	Heart Rate Beats/min.	Temperature Degrees Fahrenheit	Tremor Tester Hand Steadiness	Blood Pressure mm. Hg.
PRETEST						
IMMEDIATE						
5 min.						
10 min.						
15 min.						

COMMENTS:

BIOFEEDBACK PROJECT:

POST-SURVEY AND EVALUATION:

NAME: ______________________________

AGE: ____________

DATE: ________________

CHECK ONE:

NON-SMOKER: ( )

SMOKER: ( )

EX-SMOKER: ( ) -decided to quit
after biofeedback
program.

NON-SMOKER: DO PART A, C AND D

SMOKERS AND EX-SMOKERS: DO PART B, C AND D

PART A:

1. DID THE BIOFEEDBACK PROGRAM REINFORCE YOUR BELIEF NOT TO START SMOKING?
YES ( ) NO ( )

2. WOULD YOU RECOMMEND THE PROGRAM TO YOUR FAMILY OR FRIENDS?
YES ( ) NO ( )

3. CIGARETTE SMOKE DOES NOT AFFECT A NON-SMOKER IN A SMOKE-FILLED ROOM.
TRUE ( ) FALSE ( )

PART B:

4. DID THE BIOFEEDBACK PROGRAMS CAUSE YOU TO QUIT SMOKING?
YES ( ) NO ( )

5. DID THE BIOFEEDBACK PROGRAM CAUSE YOU TO CUT DOWN ON THE NUMBER OF CIGARETTES YOU SMOKE?
YES ( ) NO ( )

6. DID THE PROGRAM CAUSE YOU TO CHANGE YOUR CIGARETTE BRAND TO ONE LOWER IN TAR AND NICOTINE?
YES ( ) NO ( )

PART C: CHECK TRUE OR FALSE

POST-PROGRAM KNOWLEDGE

1. THERE IS A NEGATIVE HEALTH EFFECT ON YOUR BODY AFTER ONLY ONE CIGARETTE.
TRUE ( ) FALSE ( )

2. IN A SMOKE-FILLED ROOM, NON-SMOKERS AND SMOKERS ARE BOTH AFFECTED BY CIGARETTE SMOKE IN SOME WAY.
TRUE ( ) FALSE ( )

3. CARBON MONOXIDE, A POISONOUS GAS IN CIGARETTE SMOKE, ROBS THE BLOOD OF OXYGEN.
TRUE ( ) FALSE ( )

4. NICOTINE IS THE MAIN HABIT-FORMING SUBSTANCE IN CIGARETTE SMOKE.
TRUE ( ) FALSE ( )

5. YOUR SKIN TEMPERATURE DROPS AFTER SMOKING A CIGARETTE.
TRUE ( ) FALSE ( )

6. YOUR HEART RATE DOES NOT INCREASE AFTER HAVING ONLY ONE CIGARETTE.
TRUE ( ) FALSE ( )

7. YOUR HAND IS MORE STEADY AFTER HAVING JUST ONE CIGARETTE.
TRUE ( ) FALSE ( )

PART D:

1. OVERALL, DID YOU FEEL THE PROGRAM WAS PRESENTED CLEARLY?
YES ( ) NO ( )

2. WAS IT WORTHWHILE PARTICIPATING IN THE PROGRAM?
YES ( ) NO ( )

3. DID YOU UNDERSTAND THE PURPOSE OF THE PROGRAM?
YES ( ) NO ( )

4. DID YOU UNDERSTAND WHAT EACH PIECE OF EQUIPMENT WAS MEASURING?
YES ( ) NO ( )

5. DID THE INSTRUCTOR EXPLAIN EACH PIECE OF EQUIPMENT CLEARLY?
YES ( ) NO ( )

IN YOUR OWN WORDS, PLEASE EVALUATE THE PROGRAM AND ADD ANY FURTHER COMMENTS:

MEMO

TO: Parents and Guardians
FROM: Jeanette Dippo, Health Educator/Coordinator
DATE: April 10, 1981
RE: Biofeedback Smoking Project

The American Lung Association of Central New York State has made available to our health education students their new biofeedback equipment. With professional guidance, students will be able to conduct a survey on selected volunteers to determine the immediate effects of smoking on the body. It seems difficult for students to get concerned about long term effects - diseases that are going to appear 10 or 20 years from now. We feel it is important for young people to see that the body experiences immediate reactions.

They will be using the following instruments to measure the indicated bodily responses.

1. Carboximeter-amount of carbon monoxide in the breath and how it increases in smokers and those breathing second-hand smoke.
2. Digital heart rate monitor-pulse rate and how much it increases and for how long.
3. Digital thermometer-skin temperature and how it lowers as blood flow diminishes.
4. Temor tester-steadiness of hand as smoking impairs manual control.

Your child has expressed an enthusiastic interest in participating in this project and indicates that s/he is a smoker. In doing this program, s/he will have to refrain from smoking for the 24-hour period prior to the test. Then all of his/her bodily functions listed above will be taken.

Following the pre-smoking measurements, your child will be allowed, under supervision, to smoke one (1) cigarette. The tests will then be repeated. It will become immediately obvious what is happening to his/her own body with just one smoke! Imagine how impressed your child will be to see that what happens when you smoke doesn't wait 10-20 years to occur. It starts with each drag!

Obviously, we don't encourage students to smoke in school, but believe, by your child's agreeing to abstain for 24 hours prior to the test and then permitting only one cigarette to be smoked, s/he will probably have actually smoked less than the usual amount for that interval of time. However, for us to allow smoking at all, we must have your permission in writing. If you consent to your child's participation in this study, kindly sign and return the permission slip below.

If you are interested in seeing the equipment and students in action, please feel free to visit us at school. We are excited by the prospects this project offers and sincerely hope this will help students to make wise decisions about their health.

- -

________________________________ has may permission to participate in the
(Name of child)
Biofeedback Smoking Project.

____________________________   ____________________________
(Date)   (Signature of Parent/Guardian)

MEMO

TO: Faculty and Staff
FROM: Jeanette Dippo, Health Educator/Coordinator
DATE: April 13, 1981
RE: Biofeedback Smoking Project

The American Lung Association of Central New York State has made available to our health education students their new biofeedback equipment. With professional guidance, students will be able to conduct a survey on selected volunteers to determine the immediate effects of smoking on the body. It sometimes seems difficult for people to get concerned about long term effects - diseases that are going to appear 10 or 20 years from now. We think it is important for individuals to see that the body experiences immediate reactions.

Students will be using the following instruments to measure the indicated bodily responses.

1. Ecolyzer-a Carboximeter which indicates the amount of carbon monoxide in the breath and how it increases in smokers and those breathing second-hand smoke.
2. Cardio-Tach-a digital heart rate monitor that measures the pulse rate and how much it increases upon exposure to smoke and for how long.
3. Digital thermometer-which reveals the skin temperature in the fingers and how it lowers as blood flow diminishes upon exposure to smoke.
4. Tremor tester-that shows the steadiness of hand since smoking impairs manual control.
5. Sphymomanometer and B/P cuff-which measures blood pressure and its increase with smoking.

We are looking for volunteers on our staff who are smokers and who would consider helping us in this endeavor. We would also welcome non-smoking spouses who could go through the testing. In doing the program, there is one "zinger", you are requested to try to refrain from smoking for 12-hour period prior to the time you are scheduled for the test. Then all of measurement of your bodily functions listed above will be taken.

Following the pre-smoking measurements, you will be allowed, under supervision, to smoke one (1) cigarette. The tests will then be repeated at specified intervals. It will become immediately obvious to you what is happening to your own body with just one smoke! Imagine how impressed you will be to see that what happens when you smoke doesn't wait 10-20 years to occur. It starts with each drag!

Obviously, we don't encourage smoking, but believe, by your agreeing to try to abstain for 12 hours prior to the test and then permitting only one cigarette to be smoked during the test, you will probably have actually smoked less than the usual amount for that interval of time. However, for us to allow you to be a smoking participant, we must have your permission in writing. If you would like to agree to participate in this study, kindly sign and return the form below.

If you are interested in seeing the equipment and students in action, please feel free to visit us at school in the computer room or upstairs faculty room April 14-16. We are excited by tha proppects this project offers and sincerely hope this will help people to make wise decisions about their health.

(Detach and return to Jeanette Dippo by end of day Monday, 4/13/81.)

I am interested in participating in the Biofeedback Smoking Project. I prefer to be tested during mod _____. on _____________
(date)

_______________ (Date)

_______________ (Signature)

FACTS SHEET

Blood Pressure - Physiology, Risk Factors, Treatment

Blood Pressure Physiology

The function of the heart is to pump blood to the tissues of the body. The circulation of blood through the body is necessary to provide nutrients and remove wastes from the cells. The heart beats an average of 75 times each minute, varying with environmental and emotional factors. Pumping 75 gallons an hour, the heart works ceaselessly throughout life.

As blood leaves the heart it is rich in oxygen, giving it a characteristic bright red color. Traveling a system of blood vessels that is 60,000 miles in total length, the blood pulses through arteries and arterioles to the capillaries where oxygen passes to the cells and wastes pass into the blood. From the capillaries, the oxygen depleted blood travels through veins back to the heart and lungs.

As blood moves through the blood vessels, it pushes against the walls exerting pressure, thus the term blood pressure. When the heart contracts blood is pushed into the aorta; at this point the blood pressure is the greatest. This is called the systolic pressure because it occurs when the heart is in the contracted or systolic phase. Blood pressure declines as blood travels through the system. The diastolic blood pressure is the force of blood as it returns to fill the heart during the relaxed or diastolic heart phase. When blood pressure is measured both the systolic and the diastolic pressures are recorded. The systolic blood pressure is the upper or first recorded value, and the diastolic is the lower or second value recorded.

The level of blood pressure will depend on how fast the heart is pumping and the diameter of the arterioles. Normally, the walls of the arteries expand and contract to accomodate the pulse of blood flow. If arterioles contract or bear down on the blood flow, resistance will increase.

Throughout the day, blood pressure will change with the physical and emotional demands put on the body. For example, a run upstairs will create oxygen demand by the muscles. The heart will pump faster to supply oxygen rich blood. This increased cardiac output will result in a rise in blood pressure. In normal individuals, blood pressure declines while sleeping or resting.

In some people, the blood pressure is constantly elevated. This condition is called high blood pressure or hypertension. In most cases (90 - 95%), the cause of high blood pressure is not known. This is often called essential hypertension or primary hypertension. High blood pressure damages blood vessels and strains the heart. It may result in:

1) heart failure
2) arteriosclerosis
3) damage to small blood vessels, particularly in the eyes, lungs and kidneys

There are no symptoms for high blood pressure. A diagnosis of high blood pressure may only be made by taking several blood pressure measurements on different occasions using an instrument called a sphygmomanometer. One out of every four adults has high blood pressure, or about 34 million Americans. In our culture, blood pressure tends to increase as people get older. It tends to be higher in males than in females.

There are some factors which will cause temporary rises in blood pressure such as:

1) smoking
2) anxiety
3) physical activity
4) drugs, caffein

However, the disease of high blood pressure seems to be induced through a combination of genetic and environmental factors.

- race - Blacks are twice as likely to develop high blood pressure and are more vulnerable to health consequences.
- family history - Individuals whose close relatives have high blood pressure are likely to also develop the disease.
- overweight - The probability of developing high blood pressure increases with increasing body weight.
- sodium intake - In individuals with a genetic tendency toward high blood pressure, an increase in sodium intake may be associated with an increase in blood pressure.

Therapies for High Blood Pressure

When an individual is diagnosed as having high blood pressure, he/she is usually instructed to adopt the following changes in lifestyle:

1) control weight
2) stop smoking
3) eliminate stress
4) maintain a low intake of sodium (500 - 2000 mg)
5) take medication daily. Because the patient usually feels fine, extra motivation is sometimes necessary to achieve a lifelong willingness to comply with drug therapy.

High blood pressure cannot be cured, it is controlled. All of these therapies involve modifications in daily habits.

These charts present blood pressure boundaries for adolescents:

Normal Averages - Adolescents*

	Male	Female
Systolic	119 ± 13	111 ± 12
Diastolic	7[illegible] ± 10	72 ± 10

Persistent Levels Warranting Follow-Up

	Male	Female
Systolic	132	123
Diastolic	85	82

Persistent Levels Suggesting Hypertension

	Male	Female
Systolic	145	135
Diastolic	85	82

* From Heart Health Curriculum Guide, American Heart Association, Massachusetss Affiliate

In general, the lower blood pressure is, the better. If blood pressure is outside the normal range, several follow-up measurements are necessary before a diagnosis of high blood pressure is made. In adults a blood pressure reading above 140/90 would merit a follow-up.

Risk Factors of High Blood Pressure

It is not known for certain why some people develop high blood pressure.

SECRETS ABOUT YOUR BLOOD PRESSURE

FUNCTION OF HEART - TO PUMP BLOOD TO THE TISSUES OF THE BODY.

CIRCULATION OF BLOOD - NECESSARY TO PROVIDE NUTRIENTS TO AND REMOVE WASTES FROM THE CELLS.

HEART BEATS - 75 TIMES/MIN
HEART PUMPS - 75 GALLONS/HOUR
THROUGHOUT LIFE

BLOOD LEAVING THE HEART - RICH IN O_2 (BRIGHT RED)

TRAVELS THROUGH SYSTEM OF BLOOD VESSELS 60,000 MILES IN TOTAL LENGTH.

HEART
↓
ARTERIES
↓
ARTERIOLES
↓
WASTE → CAPILLARIES → O_2
↓
VENULES
↓
VEINS
↓
HEART

B/P PRESSURE HIGHEST
↓
B/P PRESSURE HIGHEST

BLOOD PRESSURE IS THE FORCE EXERTED AGAINST THE WALLS OF THE ARTERIES BY THE BLOOD BEING PUMPED.

2 READINGS:

A. SYSTOLIC - WHEN THE HEART CONTRACTS (BEATS) PUSHING THE BLOOD OUT. IT IS WRITTEN FIRST AS THE UPPER READING.

B. DIASTOLIC - WHEN THE HEART IS RELAXED FILLING BACK UP AGAIN FOR THE NEXT BEAT. IT IS WRITTEN SECOND AS THE LOWER READING.

TAKING BLOOD PRESSURE

1. ROLL UP SLEEVE IF NECESSARY, BUT DON'T ROLL SO TIGHTLY AS TO CUT OFF CIRCULATION. NEVER TAKE B/P THROUGH SLEEVE.
2. HAVE A PATIENT SIT WITH THE ARM LEVEL WITH THE HEART.
3. FEEL FOR BRACHIAL PULSE. USE 3 FINGERS AND PRESS FIRMLY AGAINST INNER PART OF ELBOW.
4. SQUEEZE ALL THE AIR OUT OF THE BLOOD PRESSURE CUFF.
5. WRAP THE CUFF AROUND THE UPPER ARM. 1-2 INCHES ABOVE THE BRACHIAL PULSE. (THE PATCH ON THE CUFF SHOULD BE FACING FORWARD WITH THE APPROPRIATE ARROW (LEFT OR RIGHT) - DEPENDING ON WHICH ARM YOU ARE USING LINED UP THE BRACHIAL PULSE.
6. FIND THE RADIAL PULSE AT THE WRIST.
7. INFLATE THE CUFF BY PUMPING THE BULB AND LOOK AT THE DIAL. NOTE WHEN THE PULSE CAN NO LONGER BE FELT. (RECORD THE # AFTER LETTING THE AIR ALL THE WAY OUT OF THE CUFF - EXAMPLE 100).
8. WAIT AT LEAST 30 SECONDS, THEN INFLATE THE CUFF TO 30MM, HG ABOVE THE PRESSURE WHEN THE RADIAL PULSE DISAPPEARED. (EXAMPLE 130)
9. PLACE THE STETHOSCOPE IN YOUR EARS WITH THE EAR PIECES POINTING AWAY FROM YOU TO BLOCKOUT THE NOISE AND FOR MORE COMFORT.
10. PLACE THE DIAPHRAGM OF THE STETHOSCOPE OVER THE BRACHIAL ARTERY.
11. INFLATE THE CUFF BY PUMPING THE BULB QUICKLY.
12. LOOSEN THE WHEEL BY TURNING IT SLOWLY TO THE LEFT LETTING THE AIR OUT OF THE CUFF. (THE BLOOD PRESSURE SHOULD DROP 2 MM.HG. FOR EACH HEART BEAT HEARD THROUGH THE STETHOSCOPE.
13. LISTEN FOR THE TAPPING SOUND OF THE HEART BEAT. WHEN IT BEGINS, NOTE THE NUMBER ON THE GAUGE. THIS IS THE SYSTOLIC BP.
14. CONTINUE TO RELEASE THE AIR FROM THE CUFF. WHEN THE TAPPING SOUND STOPS COMPLETELY, NOTE THE NUMBER ON THE GAUGE. THIS IS THE DIAGSTOLIC BP.
15. LET REMAINING AIR OUT OF THE CUFF.

TAPPING STARTS = SYSTOLIC
TAPPING STOPS = DIASTOLIC

WHEN A BP CUFF IS INFLATED AROUND AN ARM, IT SQUEEZES THE BRACHIAL ARTERY AND EVENTUALLY STOPS THE FLOW OF BLOOD.

AS AIR IS RELEASED, THE PRESSURE FROM THE CUFF IS LESS THAN THE PRESSURE OF BLOOD THROUGH THE ARTERY AND THE BLOOD FLOWS THROUGH IT AGAIN.

THE TAPPING SOUND IS THE SURGE OF BLOOD WITH EACH HEART BEAT, ITS START MARKS THE SYSTOLIC BLOOD PRESSURE.

AIR IS LET OUT OF THE CUFF, THE PRESSURE FROM THE CUFF IS LESS THAN THE PRESSURE OF BLOOD FLOW AND THE TAPPING SOUNDS STOPS. THIS IS THE DIASTOLIC BLOOD PRESSURE.

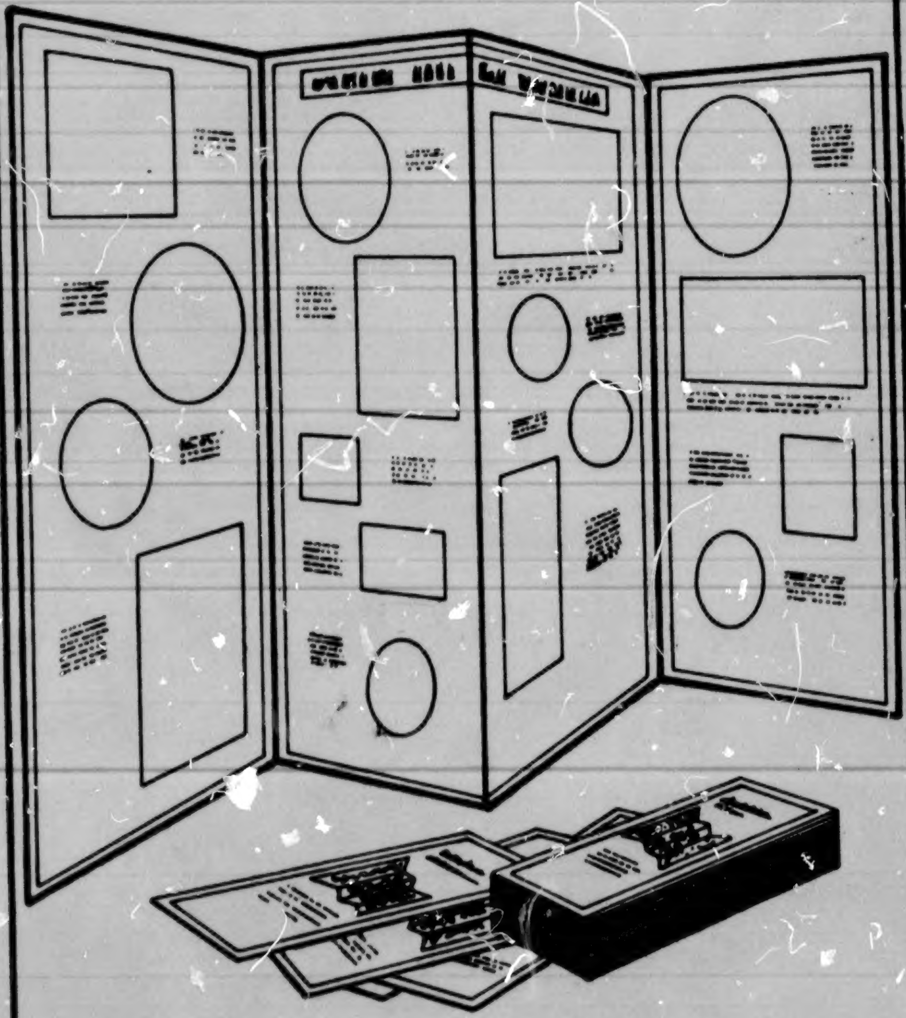
HINTS:

1. DO NOT OVER INFLATE THE CUFF:
2. IF YOU HEAR TAPPING AS SOON AS YOU BEGIN TAKING THE PRESSURE. LET THE AIR ALL THE WAY OUT OF THE CUFF, WAIT A FEW MINUTES. THEN BEGIN AGAIN BY TAKING THE RADIAL PULSE AND ADDING 30 MM. HG.
3. IF IT IS DIFFICULT TO HEAR THE PULSE DEFLATE THE CUFF AND HAVE THE "PATIENT" HOLD THE ARM OVER THE HEAD AND OPEN AND CLOSE THE FIST A FEW TIMES. THEN QUICKLY PUMP UP THE CUFF, LOWER THE ARM, AND TRY AGAIN.
4. IF A READING IS ELEVATED (OVER 130-140 SYSTOLIC), LET THE AIR ALL THE WAY, WAIT AT LEAST 2 MIN. AND TAKE THE READING AGAIN. REPEAT A SECOND TIME IF NECESSARY.

HO-37

SMOKING AND YOUR HEALTH

BY W. R. SPENCE, M.D.



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It is estimated that excess deaths caused by diseases associated with cigarette smoking exceed 300,000 per year. These diseases constitute the leading preventable causes of disability and death today. Because of these diseases, smokers have sick time rates 22% higher than non-smokers and life expectancy rates approximately 4 to 8 years less than non-smokers. In addition, the cost of smoking one package of cigarettes a day for 40 years at 8% compound interest is approximately $70,000.00.

CHRONIC BRONCHITIS

Tobacco smoke irritates the cells lining the large breathing tubes leading from the windpipe to the lungs. These cells respond by producing excessive amounts of mucus. The body expels this mucus through coughing. Persistent coughing (smoker's cough) and shortness of breath are tell-tale signs of chronic bronchitis. Fortunately, chronic bronchitis will usually disappear after smoking has been stopped.

EMPHYSEMA

Tobacco smoke coats the tiny air sacs in the lungs with tars, causing the delicate tissues to lose their normal elasticity. After years of being stressed and stretched by excessive coughing, these air sacs enlarge, break down and become useless for breathing. The emphysema cripple dies a slow smothering death from lack of oxygen in the body. Unfortunately, emphysema is incurable. The smoker must stop before becoming crippled.

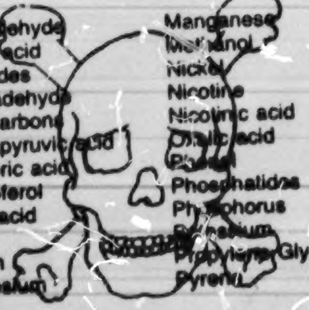
LUNG CANCER

In 1914 only 371 deaths in the USA were reported due to lung cancer. Today, cancer of the lung kills more than 75,000 Americans every year and is the leading cause of all cancer deaths. Lung cancer frequently produces no early specific symptoms and often spreads to other organs in the body (liver and brain) before being detected on x-ray. Tobacco tars have been repeatedly proved to cause lung cancer. The treatment for lung cancer is surgery, and the cure rate is less than 10%.

SMOKING AND

POISONS IN TOBACCO SMOKE

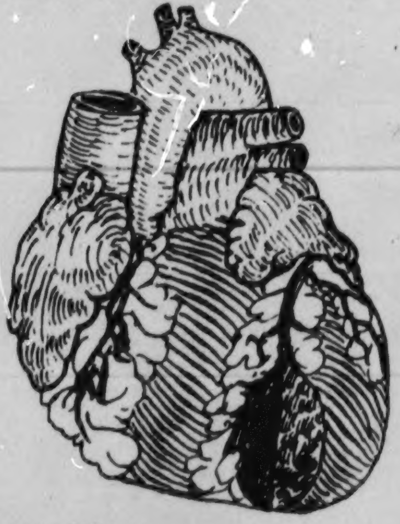
A 1-pack-a-day smoker puts approximately one quart of tobacco tars into his or her lungs every year. These tars contain over 200 identified poisons. Smoking shortens the life of a 2-pack-a-day smoker approximately 8 years. Even light smokers using 1-9 cigarettes daily shorten their life expectancy approximately 4 years.



Arsenic
Barium
Benzoic acid
Boron
Caffeic acid
Carbon
Cesium
Chromium
Copper
Ethanol
Ethyl acetate
Ferulic acid
Formaldehyde
Formic acid
Glycerides
Glycoladehyde
Hydrocarbons
Hydroxpyruvic acid
Isovaleric acid
Kaempferol
Lactic acid
Lead
Lithium
Magnesium
Manganese
Methanol
Nickel
Nicotine
Nicotinic acid
Oxalic acid
Phenol
Phosphatides
Phosphorus
Potassium
Propylene Glycol
Pyrene
Pyruvic acid
Quinic acid
Resin acids
Scopolin
Silicon
Stearic acid
Strontium
Tannins
Titanium
Valeric acid
Xanthine
Zinc

HEART ATTACKS

When tobacco smoke is absorbed into the body it decreases the oxygen carrying capacity of the blood and increases the clotting rate. This reaction, combined with the increase in hardening of the arteries associated with smoking, can cause a heart attack. Heart attacks are the most frequent cause of death in America. Before the age of 50, cigarette smokers have 3 times the number of heart attacks as non-smokers. Unfortunately the first symptom of serious heart disease is usually death, as the first heart attack is fatal over 50% of the time.

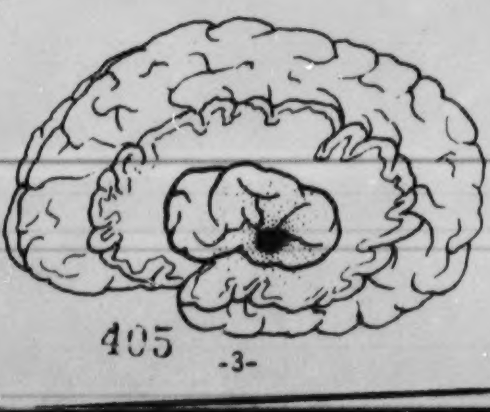


PHLEBITIS

Phlebitis is a condition marked by inflammation of the inner lining of a vein and formation of a blood clot within the vein. The disease causes swelling, stiffness, pain and red streaking at the site of involvement. Veins in the legs are most likely to be involved, but the problem can occur in the arms and abdomen. Smoking affects the clotting time of blood and increases a person's chances of suffering from phlebitis.

STROKES

Strokes are caused by bursting or clotting of blood vessels in the brain. They produce paralysis, usually of one side of the body, and may cause loss of speech and consciousness. Smoking is associated with an increase in hardening of the arteries and a decrease in blood supply to the brain. Smokers are twice as likely as non-smokers to suffer the twin tragedies of smoking—disability and death.



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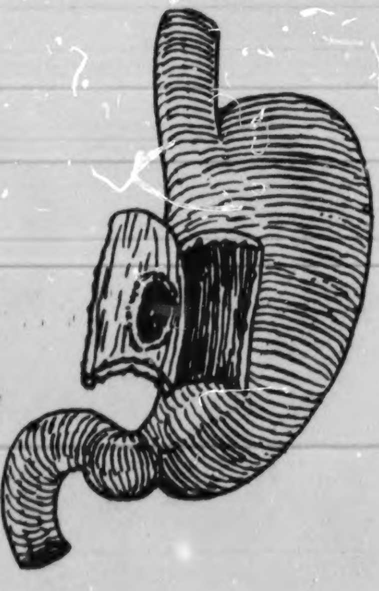
YOUR HEALTH

CAVITIES

Smokers have approximately twice the number of cavities as non-smokers because tobacco tars contribute to deposits of materials known as plaque. Plaque acts as a nesting place for the growth of bacteria which leads to a breakdown of the exterior surface (enamel) of the teeth. Cavities follow. Not only do smokers have yellow stained teeth and cavities, but because they also have more gum infections (gingivitis) they lose their teeth at a rate twice as high as non-smokers. A total of approximately 20 million Americans wear false teeth.

PEPTIC ULCERS

Peptic ulcers are open sores of the lining inside the stomach and duodenum. They cause stomach pains, heartburn, acid indigestion, bloating, nausea, vomiting and weight loss. These ulcers may cause death through perforation, obstruction of the passage of food, and bleeding. Ulcers are found four times as frequently in smokers as non-smokers because nicotine is absorbed into the bloodstream and causes an abnormal increase in acid production by the stomach.



BIRTH DEFECTS

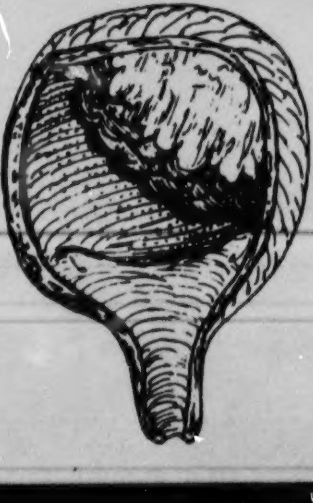
Poisons of tobacco smoke pass from the bloodstream of the mother through the uterus and placenta into the unborn child. Studies have shown that smoking mothers bear infants with birth weights approximately 7 ounces less than infants born to non-smoking mothers. (It is speculated that this is related to the decrease in available oxygen and nutrients in the mother's blood caused by an increase in carbon monoxide and other poisons in the blood of smoking mothers). Because the condition of the developing fetus is so delicate, it is strongly advised that pregnant women avoid all drugs, including alcohol and smoking.

ORAL CANCER

Poisons from burning tobacco enter directly into the cells of the lining of the mouth. A look inside a smoker's mouth will show yellow-white, leathery areas in the cheek, tongue or floor of the mouth. These changes are called laukoplakia and are early abnormalities which can lead to cancer. Cancers of the lip and tongue also occur with increased frequencies in persons who chew tobacco or use snuff. Cancers of the mouth will be diagnosed in about 15,000 Americans every year and will cause approximately 7,500 deaths each year.

CANCER OF THE LARYNX

The voice box is situated at the top of the windpipe and below the root of the tongue. It is formed by 9 cartilages, connected by ligaments and lined with mucous membranes. Persistent hoarseness without pain in any person over 40 years of age is a warning sign of cancer of the larynx. This cancer is much more prone to occur in men than women and rarely occurs before the age of 40. Most cancers of the larynx are caused by cigarette smoking. Cancer of the larynx is also associated with alcoholism.



CANCER OF THE URINARY BLADDER

Blood in the urine, pain with urination and urinary infections are the leading symptoms of cancer of the bladder. Smokers have a high incidence of bladder cancer because chemicals from nicotine tars are absorbed into their bloodstream and excreted through the urine. These cancer-producing chemicals are continuously in contact with the lining of the bladder.

TEST QUESTIONS

Take this exam before and after reading the text.

T F 1. The cost of smoking one package of cigarettes a day for 40 years at 8% compound interest is approximately $40,000.

T F 2. All smokers suffer from some degree of chronic bronchitis.

T F 3. Emphysema may usually be cured with medicines and surgery, or a combination of the two.

T F 4. Lung cancer frequently produces no early symptoms.

T F 5. Light smokers using one to nine cigarettes daily shorten their life expectancy by approximately four years.

T F 6. Before the age of 50, cigarette smokers and nonsmokers have approximately the same risk of heart attacks.

T F 7. Phlebitis is a condition marked by hardening of the inside of arteries.

T F 8. Smokers show yellow staining of the teeth, but lose their teeth at approximately the same rate of nonsmokers.

T F 9. Smoking mothers have infants with birth weight approximately 7 ounces less than infants born to nonsmoking mothers.

T F 10. Smokers have a much higher incidence of cancer of the urinary bladder than nonsmokers.

ANSWERS:

(1)F (2)T (3)F (4)T (5)T (6)F (7)F (8)F (9)T (10)T

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TOBACCO SMOKE EMISSIONS

Fact Sheet

1. Smoke-filled air contains visible smoke particles and invisible gases that may irritate the eyes and nasal passages. These same substances may also trigger allergic reactions.

2. Several harmful gases in tobacco smoke emissions have been identified: Carbon monoxide, nitrogen dioxide, hydrogen cyanide, hydrogen sulfide, hydrocyanic acid, arsenic, and other components.

3. The least obvious and most insidious danger is that a colorless gas, carbon monoxide, may get into the nonsmoker's bloodstream in sufficient quantity to damage his heart and lungs or exacerbate heart-lung disease that he already has.

4. Inhaled carbon monoxide, in smokers and non-smokers alike, enters the bloodstream through the inner surface of the lungs. Carbon monoxide robs the body of needed oxygen and commonly leads to headaches, dizziness, and lassitude.

5. The acceptable maximum in most industrial situations is 50 parts of carbon monoxide to 1,000,000 parts of air. A roomful of cigarette smokers, investigators have found, raise the carbon monoxide content to between 20 and 80 parts per million.

6. Cigarette smoke contains 250 parts per million (ppm) of nitrogen dioxide, an acutely irritating gas possibly giving rise to nitrate, a potentially mutogenic agent. Pollution alert levels in Los Angeles have gone as high as 3 ppm.

7. Hydrogen cyanide is not found in customary forms of air pollution, yet is a highly active enzyme poison, found in cigarette smoke. Long term exposure to levels of about 10 ppm is considered dangerous. Concentration in cigarette smoke is 1,600 ppm.

8. Teams of researchers at the University of Cincinnati Medical Center reported that smoke drifting from the burning ends of cigarettes, pipes, and cigars contains cadmium which could definitely be harmful when inhaled by non-smokers.

9. The presence of tobacco smoke in the air can trigger an attack in a person plagued with chronic lung disease. The attack can result in either a mild discomfort such as a coughing spell, running eyes and nose, and impaired breathing or a more serious attack involving extreme discomfort and great difficulty in breathing.

10. Smoke from an idling cigarette contains almost twice the tar and nicotine of an inhaled cigarette and thus may be twice as toxic as smoke inhaled by the smoker. An idling cigarette contaminates the air for approximately 12 minutes while the average smoker is usually inhaling on the average for 24 seconds.

2x

11. If a non-smoker must be in the company of a smoker, he may be safer when near one who inhales because the inhaling smokers filter mainstream smoke rather effectively. Studies have shown that a smoker's lungs retain more than 85% of the volatile chemicals and particulate matter, and more than half the carbon monoxide in smoke.

12. Since pipe and cigar smokers inhale less than cigarette smokers, they contribute relatively unfiltered smoke into the air.

13. Heavy cigarette smoking while driving in traffic can harm some people. The carbon monoxide present in such a situation can interfere with the driver's ability to judge time intervals and thus lead to accidents. Ten cigarettes smoked in a closed automobile produce carbon monoxide levels up to 90 ppm.

14. 58% of adult men do not smoke and approximately 70% of adult women do not smoke. The American Medical Association estimates that at least 34 million Americans are sensitive to cigarette smoke. They have respiratory conditions which are made worse, often dangerously so, by tobacco fumes.

15. The patient who is already ill is likely to become much worse if he encounters smoke in the doctor's reception room.

16. A health survey in Detroit homes concluded that smokers' children were sick more frequently than non-smokers' children, and that the presence of tobacco smoke in the environment was associated with "lessened physical health."

17. One test made in Germany showed that smoking of several cigarettes in a closed room makes the concentration of nicotine and dust particles in a short time so high that the non-smoker inhales as much harmful tobacco as the smoker inhales from four or five cigarettes.

* * * * * * * * * * * * * * * * *

Prepared by the American Lung Association of Southeast Flordia
2701 Australian Avenue, West Palm Beach, Florida 33407

HO-39

TOBACCO, DRUGS AND ALCOHOL REVIEW

1. IF A 200 LB. MAN DRINKS THE SAME AMOUNT OF ALCOHOL AS A 140 LB. MAN, THE LARGER MAN'S BLOOD-ALCOHOL CONCENTRATION WILL BE:

A. GREATER FOR 1 HOUR
B. LESS
C. GREATER
D. THE SAME

2. WHICH OF THE FOLLOWING WILL PRODUCE THE GREATEST EFFECT ON AN INDIVIDUAL?

A. A GLASS OF WINE
B. A 12 OZ. CAN OF BEER
C. A SHOT OF WHISKEY
D. THEY ALL WILL PRODUCE THE SAME EFFECT ON AN INDIVIDUAL

3. WHICH TYPE OF ALCOHOL IS FOUND IN BEVERAGES?

A. METHYL
B. ETHYL
C. DENATURED
D. ISOPROPYL

4. A FORM OF MARIJUANA WHICH IS EIGHT TIMES AS POTENT IS KNOWN AS:

A. HEMP
B. CANNABIS
C. REEFER
D. HASHISH

5. ALCOHOL IS AN APHRODESIAC (SEXUAL STIMULANT). A = TRUE OR B = FALSE

6. THE SUBSTANCE IN TOBACCO WHICH HAS THE MOST EFFECT ON THE HEART IS:

A. TAR
B. CARBON MONOXIDE
C. NICOTINE
D. ARSENIC

7. BARBITURATES ARE OFTEN FOUND IN:

A. HEADACHE REMEDIES
B. COLD REMEDIES
C. SLEEPING PILLS
D. COUGH SYRUPS

8. ALL OF THE FOLLOWING ARE EFFECTS OF CIGARETTE SMOKING EXCEPT:

A. CONSTRICTION OF BLOOD VESSELS
B. CHRONIC BRONCHITIS AND HOARSENESS
C. INCREASED ACID IN THE STOMACH
D. CIRRHOSIS OF THE LIVER

9. IN A NUMBER OF CASES, THE USE OF LSD HAS RESULTED IN EACH OF THE FOLLOWING EXCEPT:

A. VIOLENT ACTS AS A RESULT OF PARANOID DELUSIONS
B. MENTAL BREAKDOWN
C. ACCIDENTAL DEATHS FROM ATTEMPTING SUPERHUMAN FEATS
D. PERMANENT IMPROVEMENT OF MEMORY

10. DRINKING ALCOHOL ON COLD DAYS IS A GOOD WAY TO KEEP WARM. A = TRUE B = FALSE

11. THERE ARE MANY EARLY WARNING SIGNS OF LUNG CANCER. A = TRUE OR B = FALSE

12. WHICH IS NOT AN EFFECT OF NICOTINE ON THE BODY?

A. INTERFERENCE WITH DIGESTION AND APPETITE
B. DECREASED BLOOD PRESSURE AND BREATHING & HEART RATES
C. IRRITATION OF THE NOSE, THROAT AND LUNGS
D. INCREASED HEART RATE AND BLOOD PRESSURE
E. CURARE-LIKE EFFECT (PARALYZING) ON THE CILIA

13. ALCOHOLISM IS A DISEASE WITH ALL OF THE FOLLOWING PECULIAR CHARACTERISTICS EXCEPT

A. NOT ALL PEOPLE WHO DRINK DEVELOP IT
B. THERE ARE MANY CAUSES
D. IT AFFECTS ALL PEOPLE IN THE SAME WAY
C. THERE IS NO STANDARD TREATMENT AND RECOVERY CAN'T BE PREDICTED

14. OVERDOSES OF BARBITURATES ARE DANGEROUS BECAUSE THEY

A. SPEED UP THE BREATHING RATE   C. ARE ILLEGAL DRUGS
B. SLOW THE BREATHING RATE   D. ARE STIMULANTS

15. MOST ALCOHOLICS ARE SKID ROW BUMS. A = TRUE OR B = FALSE

16. MARIJUANA VARIES GREATLY IN POTENCY. A = TRUE OR B = FALSE

17. THE USE OF METHADONE IN THE TREATMENT OF DRUG ADDICTION REPRESENTS THE REPLACEMENT OF ONE TYPE OF ADDICTION WITH ANOTHER.
A = TRUE OR B = FALSE

18. THE MOST ADDICTING DRUG IS

A. OPIUM   C. CODEINE
B. MORPHINE   D. HEROIN

19. PCP IS A MILD TRANQUILIZER PRESCRIBED MAINLY FOR PEOPLE WHO HAVE DIFFICULTY FALLING ASLEEP AT NIGHT. A = TRUE OR B = FALSE

20. ALCOHOLICS ANONYMOUS ATTEMPTS TO HELP ALCOHOLICS

A. GET MORE RESPONSIBLE JOBS   C. THROUGH LEGISLATION
B. HIDE THEIR PROBLEM   D. UNDERSTAND THEIR OWN PROBLEMS

21. LSD HAS A DISTINCT TASTE, ODOR, AND COLOR EASILY DISTINGUISHING IT FROM OTHER DRUGS. A = TRUE OR B = FALSE

22. AN EXAMPLE OF AN OPIATE IS

A. CODEINE   C. HEROIN
B. MORPHINE   D. ALL OF THESE

23. THE COMBINATION OF ALCOHOL WITH WHICH OF THE FOLLOWING IS THE MOST DANGEROUS?

A. AMPHETAMINES
B. BARBITURATES
C. COCAINE
D. MESCALINE

MATCHING:

24. THE MOST COMMON SMOKER'S COMPLAINT.
25. CONSTRICTION OF THE BLOOD VESSELS IN THE EXTREMITIES MAY EVENTUALLY LEAD TO AMPUTATION OF A LIMB OR APPENDAGE IN THIS DISORDER.
26. A CONDITION IN WHICH THE PERSON DEVELOPS A PERSISTENT COUGH (MOST NOTICEABLE IN THE MORNING) WHICH PRODUCES MUCH SPUTUM.

B. BUERGER'S DISEASE
C. CHRONIC BRONCHITIS
D. THROAT IRRITATION

27. IN TRYING TO QUIT SMOKING, WHICH OF THE FOLLOWING WOULD A PERSON NOT WANT TO DO?

A. MAKE A LIST OF ADVANTAGES AND DISADVANTAGES OF SMOKING
B. DRINK WATER
C. STOP AT A TIME OF HIGH TENSION - SO YOUR MIND WILL BE DIVERTED
D. HIDE THE CIGARETTES WHERE YOU CAN'T GET TO THEM

28. THE PROCESS OF ALCOHOL BEING "BURNED UP" IN THE TISSUES IS KNOWN AS

A. DISTILLATION
B. POTENTIATION
C. FERMENTATION
D. OXIDATION

29. THE BLOOD-ALCOHOL CONCENTRATION DEPENDS UPON WHICH GROUP OF FACTORS?

A. PRESENSE OF FOOD IN THE STOMACH, AGE, SEX, PRESENCE OF OTHER DRUGS
B. ALCOHOL CONCENTRATION, TIME OF DAY TAKEN, FATIGUE LEVEL, AGE
C. SPEED OF DRINKING, PRESENCE OF COMMUNICABLE DISEASES, NUTRITION LEVEL
D. BODY WEIGHT, SPEED OF DRINKING, PERCENTAGE OF ALCOHOL IN DRINK, RECENTNESS OF EATING

30. THE SYNTHETIC NARCOTIC METHADONE IS

A. NON-ADDICTIVE
B. PROBABLY THE ONLY SAFE DEPRESSANT
C. CAUSE OF THE HARDEST ADDICTION TO TREAT
D. USED MEDICALLY TO TREAT HEROIN ADDICTION

31. WHEN A PERSON WHO SMOKES AND DRINKS DEVELOPS ULCERS, GENERALLY HE/SHE SHOULD

A. STOP SMOKING
B. STOP DRINKING
C. NOT ATTEMPT TO STOP SMOKING OR DRINKING AS THIS WILL GENERATE MORE NERVOUSNESS AND AGGRAVATE THE ULCERS
D. A & B

32. APPROXIMATELY 10% OF ALL PEOPLE WHO BEGIN TO USE MARIJUANA WILL BECOME REAL POTHEADS. B = TRUE OR A = FALSE

33. TRUCK DRIVERS, NIGHT WORKERS, AND STUDENTS DURING EXAMS ARE TYPES OF PEOPLE WHO TEND TO MISUSE BARBITURATES. A = TRUE OR B = FALSE

34. ABOUT 10% OF ALL PEOPLE WHO BEGIN TO DRINK WILL BECOME ALCOHOLICS. B = TRUE OR A = FALSE

35. AUTOPSY EXAMINATIONS OF SMOKERS' LUNGS REPEATEDLY SHOW THAT

A. BRONCHIAL CILIA ARE DESTROYED
B. ABNORMAL CELL GROWTHS APPEAR
C. LUNG TISSUE IS BLACK FROM SMOKE AND TAR
D. ALL OF THESE

36. SIPPING OR DRINKING MODERATE AMOUNTS OF ALCOHOLIC BEVERAGES WILL KEEP BLOOD-ALCOHOL CONCENTRATIONS LOWER THAN IF THE BEVERAGE IS CONSUMED RAPIDLY. A = TRUE OR B = FALSE

37. HABITUAL USE OF AMPHETAMINES CAN RESULT IN HALLUCINATIONS. A = TRUE OR B = FALSE

38. THE FIRST STEP IN THE TREATMENT OF THE ALCOHOLIC IS TO WITHDRAW HIM FROM ALCOHOL. B = TRUE OR A = FALSE

39. THE UNSTABLE PERSONALITY APPEARS TO BE MOST NEGATIVELY AFFECTED BY HALLUCINOGENIC DRUGS. B = TRUE OR A = FALSE

40. WHICH ONE OF THE FOLLOWING IS NOT TRUE ABOUT TEENAGERS WHO TEND TO BECOME ALCOHOLICS LATER IN LIFE?

A. PARENTS ARE FREQUENTLY ALCOHOLICS
B. ENJOY DEFYING ADULTS
C. OFTEN HAVE POOR ADJUSTMENT IN SCHOOL
D. GENERALLY COME FROM LOW IMCOME FAMILIES

41. ALCOHOL, WHILE MAKING A PERSON FEEL WARMER, ACTUALLY DECREASES BODY TEMPERATURES. B = TRUE OR A = FALSE

42. SHORT-WINDEDNESS ASSOCIATED WITH SMOKING IS THE RESULT OF THE EFFECTS OF

A. AMMONIA
D. CARBON MONOXIDE
C. OXYGEN
B. TARS

43. ALCOHOL IS A STIMULANT. A = TRUE OR B = FALSE

MATCHING

44. FEELING OF ILLNESS THAT USUALLY OCCURS THE MORNING AFTER A BOUT OF HEAVY DRINKING.
45. SEVERAL DAYS OR WEEKS OF CONSTANT DRINKING.
46. TAKING DRINKS IN THE MORNING UPON ARISING IN ORDER TO RELIEVE THE SHAKES, ETC.

B. BENDERS
C. EYE OPERNERS
D. HANGOVER

47. A DRUG THAT IS OFTEN USED IN PLACE OF MORPHINE IN MEDICAL TREATMENT

A. BENZEDRINE
B. HEROIN
C. DEMEROL
D. NICOTINE

48. THE AVERAGE ADULT CAN BURN UP HOW MANY OUNCES OF 100-PROOF WHISKEY PER HOUR?

A. ¼ - ½
B. 10
C. 2-3
D. 1/3 to 1

49. A PREGNANT MOTHER WHO SMOKES IS AFFECTING HER UNBORN CHILD IN ALL OF THE FOLLOWING WAYS EXCEPT

A. INCREASING CHILD'S CHANCES OF BEING STILLBORN
B. RETARDING CHILD'S GROWTH
C. INCREASING CHILD'S CHANCES OF DYING SOON AFTER BIRTH
D. SENDING TOO MUCH OXYGEN TO THE FETUS IN THE UTERUS

50. THE PRESENCE OF PROTEIN AND FAT IN THE STOMACH SPEED THE ABSORPTION OF ALCOHOL. A = TRUE OR B = FALSE

51. A DEVELOPMENTAL CONDITION CHARACTERISTIC OF BABIES BORN TO SOME MOTHERS WHO TOOK SUCH DRUGS AS LSD OR THALIDOMIDE DURING PREGNANCY IS

A. BERI-BERI
B. PHOCOMELIA
C. PELLAGRA
D. FETAL ALCOHOL SYNDROME

52. IN SUBZERO TEMPERATURES° THE POSSIBLITY OF FROSTBITE OF THE FINGERS AND TOES IS LESS IN THE SMOKING INDIVIDUAL. A = TRUE OR B = FALSE

53. THE "PROOF" OF AN ALCOHOLIC BEVERAGE IS

A. ONE-HALF OF ITS ALCOHOLIC CONTENT
B. THE SAME AS ITS ALCOHOLIC CONTENT
C. THE ALCOHOLIC CONTENT THAT REMAINS AFTER A DRINK HAS BEEN TAKEN
D. TWICE ITS ALCOHOLIC CONTENT

54. BARBITURATES ARE USUALLY REFERRED TO AS "PEP" PILLS. A = TRUE OR B = FALSE

MATCHING

55. MADE FROM MORPHINE AND USED IN COUGH SYRUPS.
56. DRUGS USED TO SUPPRESS APPETITE AND USED IN WEIGHT CONTROL.

A. AMPHETAMINES
B. CODEINE

57. ADVERTISING OF DRUGS, INCLUDING ALCOHOL AND TOBACCO, IN THE MEDIA USUALLY DEPICTS REALISTIC SITUATIONS. B = TRUE OR A = FALSE

58. AFTER GIVING UP SMOKING, MANY PEOPLE EXPERIENCE

A. LOSS OF WEIGHT
B. LOSS OF APPETITE
C. INCREASED HAIR GROWTH
D. FEWER RESPIRATORY DISTURBANCES

MATCHING

59. PRODUCED BY THE FERMENTATION OF GRAINS AND MALT.
60. AN ACUTE FORM OF MENTAL ILLNESS THAT OCCURS IN ONE OUT OF EVERY TEN ALCOHOLICS.
61. THE MAIN EFFECT THAT ALCOHOL HAS ON THE BODY.

B. BEER
A. DEPRESSANT
C. KORSAKOFF'S SYNDROME

62. THE PROCESS OF DISTILLATION WOULD BE USED TO PRODUCE WHICH OF THE FOLLOWING?

A. BEER
B. WINE
C. FORTIFIED WINE
D. GIN

63. SNIFFING OF TOXIC SOLVENTS CAN CAUSE BRAIN° LIVER° OR KIDNEY DAMAGE. A = TRUE OR B = FALSE

64. THE PERCENTAGE OF FATAL AUTOMOBILE ACCIDENTS ASSOCIATED WITH ALCOHOL INTOXICATION IS

A. 20%
B. 40%
C. 50%
D. 60%

65. AN INADEQUATE NUTRITIONAL STATE IS OFTEN ASSOCIATED WITH HEAVY DRINKING OF ALCOHOLIC BEVERAGES. A = TRUE OR B = FALSE

66. THE PHYSICAL EFFECT THAT IS NOT CHARACTERISTIC OF THE USE OF MARIJUANA IS

A. TALKATIVENESS
B. INCREASED APPETITE
C. IMPROVED REACTION TIME
D. DELUSIONS

67. A PHYSICIAN WITH A VERY ANXIOUS AND TENSE PATIENT MAY PRESCRIBE A COMMONLY MISUSED DRUG CALLED

D. VALIUM
B. COCAINE
C. AMPHETAMINES
A. HEROIN

68. THE DRUG MARIJUANA CAN BE

A. ADDICTING
B. PHYSICALLY HABIT FORMING
C. SOCIALLY AND PSYCHOLOGICALLY HABIT FORMING
D. ALL OF THE ABOVE

69. ALL OF THE FOLLOWING HAVE AN INFLUENCE ON HOW ALCOHOL WILL AFFECT A PERSON EXCEPT

A. PRESENCE OF FOOD IN THE STOMACH AND RATE OF CONSUMPTION
B. CONCENTRATION OF ALCOHOL IN THE BEVERAGE
C. SIZE OF THE PERSON
D. EXERCISING TO BURN UP THE ALCOHOL

70. WHICH IS NOT AN EFFECT OF THE CARBON MONOXIDE FOUND IN CIGARETTE SMOKE?

A. DECREASED VISION DUE TO DECREASED SENSITIVITY OF THE EYES
B. DECREASED PHYSICAL PERFORMANCE-ESPECIALLY STRENUOUS ACTIVITIES
C. INCREASED TOLERANCE TO HIGH ALTITUDES
D. DECREASED OXYGEN-CARRYING CAPACITY OF THE BLOOD

71. VITAMIN PILLS ARE DRUGS. A = TRUE OR B = FALSE

72. WHICH IS NOT A STEP TO BE TAKEN IF A PERSON IS TRYING TO QUIT SMOKING?

A. BE SURE YOU WANT TO QUIT AND KNOW THE REASON WHY YOU WANT TO
B. CHOOSE A PARTICULAR DAY WHEN YOU ARE NOT GOING TO BE ESPECIALLY TENSE AND STOP COMPLETELY
C. SMOKE A CIGARETTE OCCASIONALLY IF YOU GET TENSE
D. DON'T THINK THE HABIT IS LICKED EVEN AFTER SIX MONTHS

73. THE MAJOR PHYSICAL EFFECT OF LONG-TERM USE OF MARIJUANA DISCOVERED TO DATE IS IN THE AREA OF RESPIRATORY IRRITATION. A=TRUE OR B=FALSE

74. A PERSON WHO IS AN ALCOHOLIC

A. OCCASIONALLY HAS AN ALCOHOLIC DRINK
B. CONSUMES MORE THAN TWO ALCOHOLIC DRINKS DAILY
C. WILL DIE FROM EXCESSIVE USE OF ALCOHOL
D. IS UNABLE TO CONTROL THE USE OF ALCOHOL

75. MARIJUANA LAWS IN THE UNITED STATES HAVE RECENTLY BECOME MORE RESTRICTIVE. B=TRUE OR A=FALSE

76. THE BEST WAY TO RELIEVE FEELINGS OF ANXIETY IS TO

A. TAKE SEDATIVES OR AN ALCOHOLIC DRINK
B. TAKE STIMULANTS
D. ATTEMPT TO SOLVE THE PROBLEM
C. TAKE TRANQUILIZERS

77. THE CILIA OF THE RESPIRATORY TRACT ARE AFFECTED BY

A. AMMONIA
B. CARBON MONOXIDE
C. NICOTINE
D. CARBON DIOXIDE

78. WHAT IS MEANT BY "TOLERANCE" IN SPEAKING OF DRUG ADDICTION INCLUDING ALCOHOL?

A. A SENSE OF WELL-BEING AND RELAXATION CAUSED BY THE DRUG
B. EMOTIONAL DEPENDENCE ON THE DRUG
C. THE NEED FOR LARGER DOSES OF THE DRUG WITH CONTINUED USE
D. PHYSICAL DEPENDENCE ON THE DRUG

MATCHING

79. DISORDER IN WHICH THE AIR SACS (ALVEOLI) BECOME DISTENDED AND RUPTURE CAUSING THE PERSON GREAT DIFFICULTY IN BREATHING.
80. MADE BY THE FERMENTATION OF FRUIT JUICES.
81. MEMORY LAPSES FOR EVENTS WHICH OCCURRED WHILE DRINKING.

B. BLACKOUTS
C. EMPHYSEMA
D. WINE

82. A STUDY OF HIGH SCHOOL STUDENTS' SMOKING HABITS FOUND

A. THE KEY FACTOR WAS NICOTINE CRAVING
B. THE MOST IMPORTANT FACTOR WAS ORAL SATISFACTION AND SELF-ASSURANCE
C. YOUNG ADULTS SMOKED PRIMARILY TO REDUCE TENSION
D. THE MOST IMPORTANT FACTOR WAS WHETHER THE PARENTS SMOKED

83. NOBODY CAN BECOME AN ALCOHOLIC BY DRINKING JUST BEER. A=TRUE OR B=FALSE

MATCHING

84. ALCOHOL IRRITATES THE LINING OF THE STOMACH BY INCREASING THE FLOW OF HYDROCHLORIC ACID RESULTING IN THIS DISORDER.
85. PERIOD OF ILLNESS DURING WITHDRAWAL FROM ALCOHOL WHEN THE ALCOHOLIC IS TERRIFIED, HAS HALLUCINATIONS AND IS VERY SICK.
86. A CONDITION IN WHICH THE LIVER SWELLS AS FAT REPLACES FOODS NORMALLY STORED THERE.

B. DELIRIUM TREMENS
C. FATTY LIVER
D. GASTRITIS

87. WHICH OF THE FOLLOWING HAS THE HIGHEST ALCOHOLIC CONTENT?

A. A 12 OZ. BOTTLE OF BEER
B. A 4 OZ. GLASS OF WINE
C. A "SHOT" OF WHISKEY
D. THEY ARE ALL THE SAME

88. ALCOHOL LOWERS ONE'S DRIVING EFFICIENCY IN ALL OF THE FOLLOWING WAYS EXCEPT

A. GIVES A FALSE SENSE OF SECURITY AND PROMOTES DISCOURTESY
B. DECREASES VISUAL ABILITY AND DISTANCE JUDGMENT
C. CAUSES PERSON'S MIND TO BE ON EVERYTHING BUT HIS DRIVING AND MAKES IT DIFFICULT FOR HIM TO ASSOCIATE DANGER SIGNALS WITH DANGER
D. DECREASES REACTION TIME

89. CANCER OF THE LUNG IS

A. EASILY CURED
B. MAINLY DUE TO TENSION
D. NOT AS FREQUENT AMONG NONSMOKERS
C. MAINLY DUE TO AIR POLLUTION

90. THE ACTIVE INGREDIENT (MOLECULE) IN MARIJUANA IS KNOWN AS

- A. PCP
- B. HEMP RESIN
- C. MARIGUANO
- D. THC

91. MARIJUANA AND DRIVING DON'T MIX BECAUSE MARIJUANA ADVERSELY AFFECTS REACTION TIME, AS WELL AS VISUAL AND TIME PERCEPTION.
B = TRUE OR A = FALSE

92. THE ONE WHICH IS NOT ONE OF ALCOHOL'S PROGRESSIVE EFFECTS ON BEHAVIOR IS

- A. DISTURBANCE OF THE SENSE ORGANS
- B. DECREASED MUSCULAR CONTROL/COORDINATION
- C. DEPRESSED VITAL BODY ACTIVITIES
- D. IMPROVED INTELLIGENT DECISION-MAKING

93. A MAJOR CONCERN IN THE USE OF ALCOHOL IS THE FREQUENCY OF DRINKING OF ALCOHOLIC BEVERAGES. B = TRUE OR A = FALSE

MATCHING

94. A NERVOUS SYSTEM DRINKERS ASSOCIATED WITH THE LACK OF B VITAMINS IN HEAVY DRINKERS IS CALLED.

95. THE CHARACTERISTICS OF A POORLY DEVELOPED BABY WITH ASSOCIATED PHYSICAL AND MENTAL DEFECTS DUE TO THE MOTHER'S DRINKING DURING PREGNANCY IS CALLED.

96. HARDENING AND SCARRING OF THE LIVER WHICH OCCURS 8 TIMES AS OFTEN IN ALCOHOLICS AS IT DOES IN NONDRINKERS.

- C. CIRRHOSIS
- B. FETAL ALCOHOL SYNDROME
- D. NEURITIS

97. WHEN ONE HAS COLD HANDS OR FEET IN THE WINTERTIME IT IS UNWISE TO SMOKE BECAUSE

- A. NICOTINE CAUSES AN INCREASE IN THE HEART RATE
- B. BODY HEAT IS LOST BY PUFFING
- C. NICOTINE CAUSES NARROWING OF THE BLOOD VESSELS
- D. AMMONIA PRODUCES A COOLING EFFECT

98. BARBITURATES, COMMONLY FOUND IN SLEEPING PILLS, ARE

- A. LESS DANGEROUS THAN NARCOTICS
- B. DANGEROUS BUT NONADDICTIVE
- C. TAKEN BY VERY FEW PEOPLE IN THE UNITED STATES
- D. THE CAUSE OF MANY SERIOUS PROBLEMS

99. THE FACT THAT ALCOHOLISM RUNS IN FAMILIES, SUPPORTS WHICH POPULAR THEORY?

A. CULTURAL
B. PSYCHOANALYTIC
C. DEVIANT BEHAVIOR
D. GENETIC

100. ALCOHOL AFFECTS ONLY A SMALL PORTION OF THE ADULT POPULATION. A = TRUE OR B = FALSE

101. INHALING HAS LITTLE OR NO EFFECT ON THE POSSIBILITY OF DEVELOPING LUNG CANCER. A = TRUE OR B = FALSE

HO-40

Quiz Whiz Answer Key

1. B
2. D
3. B
4. D
5. B
6. C
7. C
8. D
9. B
10. B
11. B
12. B
13. D
14. B
15. B
16. A
17. A
18. D
19. B
20. D
21. B
22. D
23. B
24. D
25. B
26. C
27. C
28. D
29. D
30. D
31. D
32. B
33. B
34. B
35. D
36. A
37. A
38. B
39. B
40. D
41. B
42. D
43. B
44. D
45. B
46. C
47. C
48. D
49. D
50. B
51. B
52. B
53. D
54. B
55. B
56. A
57. B
58. D
59. B
60. C
61. A
62. D
63. A
64. C
65. A
66. C
67. D
68. C
69. D
70. C
71. A
72. C
73. A
74. D
75. A
76. D
77. C
78. C
79. C
80. D
81. B
82. D
83. B
84. D
85. B
86. C
87. C
88. D
89. D
90. D
91. B
92. D
93. B
94. D
95. B
96. C
97. C
98. D
99. D
100. B
101. B

ATTAINABLE ALTERNATIVES

LET US SHOW YOU SOMETHING BETTER

ATTAINABLE ALTERNATIVES

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I. Cortland County Mental Health Clinic

III. Community Agencies and Services - (cont.)

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    2. Family Counseling
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ALTERNATIVES TO DRUGS

Let Me Show You Something Better

Motives for drug taking, whatever diverse pressures generate this behavior, inevitably include the need to escape from boredom, alienation, pain, frustration and meaninglessness. People take drugs because they make them feel better. Non-chemical alternatives to drug abuse are defined to include those constructive and viable attitudes, values, orientations, experiences, lifestyles, opportunities, activities, pursuits and programs which can prevent significant drug abuse or diminish drug abuse by providing greater satisfactions than can drugs.

To be acceptable and attractive, any alternatives we offer must be realistic, attainable and meaningful. Any proposed alternative must assist people to find self-understanding, improved self-image, feeling of significance, expanded awareness, or new experiences which they seek through drugs.

A common tendency in child rearing practices of the animal kingdom has been observed. The parents prevent undesirable behavior by diverting the attention of their young toward an acceptable activity. This provision of alternative behavior appears to have a positive effect upon healthy development of the young. Humans need any help we can get to prevent drug abuse and can ill afford to ignore such excellent guidance.

UNPLEASANT REALITIES

To offer alternatives to drug abuse requires accepting certain, perhaps unpleasant, realities. Consider these:

1. The use of mood-altering substances is usually pleasurable. People *use* drugs to "feel better" or to "get high". Individuals *experiment* with drugs out of curiousity or hope that the drugs can, in some way, make them feel better. People *abuse* drugs due to personal deficiencies.

2. People start and continue to use (abuse) drugs, at least to the point of addiction, because they want to do so, not because of some intrinsic nature of the drug.

3. Drugs do not compel behavior. They may lessen inhibitions or interfere with logical thinking, thus allowing unusual behavior. However, drugs do not, of themselves, produce any actions by the person.

4. Psychological dependence results when the drug effect fills a need or is a people substitute. *Any* activity or agent which gives pleasure or relieves discomfort may be associated with psychological dependence.

5. Drug users are not necessarily immature, immoral, irresponsible, socially disadvantaged, alienated, rebellious, or mentally ill. Drug use is a part of the continuum of human existence.

6. All use of illegal or socially disapproved drugs is not necessarily abusive, much less addictive. Some *legal* drug use is abusive because it produces physical, psychological, or social damage.

7. The important factor in many forms of pleasure seeking (gratification) behavior is the resultant change in the mood or consciousness of the person.

8. Our society appears to stress experience as a prerequisite for maturity. Some drugs are alleged to give experience quickly, painlessly and effortlessly.

9. Individuals do not stop using mood-altering substances or pleasure-seeking behavior until they discover something better.

10. The alternatives to drug abuse are also alternatives to the distresses and discomfort which lead to any self-destructive behavior.

LEVELS OF EXPERIENCE AND EXAMPLES OF

ALTERNATIVES TO DRUGS

The following list from "Alternatives to Drug Abuse: Steps Toward Prevention", National Institute on Drug Abuse, covers a broad range of pursuits, all of which could have potential impact on certain individuals at certain stages of their development. It is helpful to be aware of the breadth of creative possibilities; however, these options also require crystallization into action.

Level of Experience Type of Gratification	Corresponding Motives, Needs Aspirations	Alternative Example
A. Physical:	Physical relaxation Relief from pain or anticipated prevention of sickness Increased physical energy, avoidance of fatigue	1. Relaxation exercises; "hatha" (physical) yoga 2. Dance and movement training 3. Training in preventive medicine; positive health habits 4. Dietary and nutritional training and habits 5. Physical recreation; competitive athletics (especially for fun); individual physical conditioning (e.g., jogging, exercise); hiking, nature study, certain outdoor work, etc. 6. Gentle addiction withdrawal 7. Experience and training in the martial arts, e.g. aikido, karate, judo

Level of Experience Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
B. Sensory:	Intensification/enrichment of sensory input (e.g., sound, sight, touch, etc.) Enhancement of sexual experience	1. Sensory awareness training (including increased awareness of body position, balance, coordination, small muscle control, learning to diminish or intensify sensory input)
		2. Massage
		3. Visual exploration of nature
		4. Responsible sexuality (e.g., possible education in noncoital sexuality for adolescents)
C. Emotional:	Psychological escape or release from emotional agony	1. Competent, empathic individual counseling
	Reduction of normal tension, anxiety, conflict	2. Competent, empathic group psychotherapy
	Emotional relaxation	3. Special therapeutic techniques, e.g. psychodrama and role-playing (expertly conducted)
	Mood alteration	
	Desire for psychological emotional insight	4. Instruction in the psychology of personal development (e.g. in secondary schools)
	Avoidance of decision-making: pressure avoidance	5. Affective education (including techniques like values clarification, especially in primary grades)
	Desire for privacy, aloneness	
	Rebellion, assertion of independence or defiance of authority	6. Emotional awareness exercises, e.g. learning body language, honest open self-awareness, psychological awareness workshops and seminars (especially for adults)
	Intensification of personal courage	
	Increase of self-esteem	

Level of Experience Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
D. Interpersonal:	Gain in peer recognition as in "showing off" Gain in peer acceptance, as in behaving according to "peer pressure" Relaxation of interpersonal inhibition ; facilitation of social interaction Reduction of anxiety-provoking intimacy Reduction in barriers to communication ; also solution of interpersonal problems Escape /release from family difficulties Escape/release from feelings of loneliness , alienation Establishment of feeling of "community" or belonging with actual or reference group	1. Creation of alternate peer groups 2. Competently run, empathic experiences in peer and group process (including group discussion, sensitivity and encounter groups) 3. Competent, empathic group psychotherapy 4. Various "experiences in being," including interpersonal workshops aimed at development of caring, personal responsibility, confidence, trust and respect for others 5. Psychodrama, role-playing and other special techniques (expertly conducted) 6. Competent empathic individual counseling for interpersonal troubles 7. Goal-directed, positive group activities through organizations such as Scouts, 4-H, FHA, school clubs, church organizations, etc. 8. Social confidence training, instruction in social customs, "manners" of human interaction (especially for shy children) 9. Self-examination of relationships

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
D. Interpersonal: (cont)		10. Family life education and training
		11. Family therapy, family counseling, parent education
		12. Premarital and marital counseling /education
		13. Temporary alternate families, alternate foster homes
		14. Emotional "tutoring", e.g., big brothers and sisters helping younger people
		15. Creation of community "rap centers"
E. Mental-Intellectual:	Reduction of boredom Curiousity	1. Mental / intellectual hobbies and games ; e.g., puzzles, chess, etc.
	Enhancement of learning processes	2. Intellectual excitement through reading and discussion
	Problem-solving, especially technical Research on oneself, one's cognitive processes	3. Intellectual challenge through education, exploring frontiers of knowledge, simulating curiosity
	Mental fatigue avoidance, as in studying	4. Introspection; analysis of thought
		5. Memory training
		6. Training in problem-solving and decision-making, e.g., "Synectics" training
		7. Concentration and attention exercises
		8. Training in mind control, e.g., "psychocybernetics", auto suggestion, positive thinking, etc.

Level of Experience: Type of Gratification	Correspoinding Motives, Needs Aspirations	Alternative Example
F. Creative-Aesthetic:	Increase in creative performance ability Increase in enjoyment of artistic productions	1. Non-graded instruction or experiential opportunity in appreciation of artistic productions, e.g., music, art, drama, etc.
	Creation of subjective states of fantasy or imagination	2. Opportunities for artistic participation, e.g., non-graded lessons in art, music, drama, etc.
		3. Creative hobbies (e.g., crafts, sewing, cooking, gardening, handiwork, photography, etc.)
		4. Experience in communication skills, e.g., writing, public speaking, media, conversation, etc.
		5. Theater games, other procedures encouraging imagination and creative fantasy.
		6. Creation of community centers for the arts
G. Experiential:	Desire for "pure pleasure," "fun," recreation	1. Self-generated play experience
	Nonspecific changes in consciousness or awareness, e.g., any "high", intoxication for its own sake, desire for a change, any change, in experience	2. Experiments in sensory deprivation 3. Biofeedback training, e.g., alpha wave training
	Unusual distortion of the sensorium, "freaky" perception and associated experience	4. Sleeplessness & fasting (natural procedures for "intoxicated" states, only with health parameters)
	Engagement- the need to be personally and totally involved in the moment, whatever the experience; counteracting apathy and ennui	5. "Mind-tripping", e.g., guided daydreams and fantasy 6. Hypnosis (expertly conducted)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
H. Stylistic:	Need for identification through imitation, by youth of adults, by adults of youth, from media and subcultural "hero" figures; peer imitation Automatic chemical reliance,-i.e. the culturally infused style of substance ingestion for any perceived deficiency Desire for immediacy of achievement, impatience, intolerance of delay of gratification	1. Exposure to others deeply and meaningfully involved in non-chemical alternatives 2. Exposure to "hero" figures unfavorable to chemical abuse 3. Enlistment in anti-drug or alternative programs 4. Exposure to philosophy of enjoying the process of attainment, not just the product 5. Parental abstinence and moderation in drug use (parent agreement to cut down to give better example to children) 6. Exposure to philosophy of the "natural," education regarding the artificiality of chemical dependence
I. Social-Political:	Identification with anti-establishment forces Rebellion against disliked laws Overcoming discouragement or desperation with social-political future Induced change in mass consciousness, sometimes by attempted disruption of "the system"	1. Partisan political action, e.g.,helping candidate campaigns 2. Non-partisan lobbying, e.g., for ecological projects 3. Personal political involvement, e.g., running for elective or organizational office 4. Field work with politicians and public officials

Level of Experience: Type of Gratification	Motives, Needs, Aspirations	Alternative Example
I. Social-Political: (cont)		5. Involvement in social service, including:
		a. Providing voluntary service to the poor (e.g., day care for working mothers, helping to locate housing, assisting access to health services, etc.)
		b. Providing companionship to the lonely (e.g., companions for the aged, foster children, prison inmates, etc.)
		c. Work with schools (e.g., student tutoring programs, volunteer teaching assistants and counselors, etc.)
		d. Work with drug abuse problems (e.g., peer or volunteer counseling, information provision)
		e. Work in preserving environment (e.g., recycling, identifying pollution, preservation of areas natural beauty)
		6. Participation in ACTION (e.g., VISTA and Peace Corps)
		7. Citizen "potency" training (i.e., learning effectiveness with Government and bureaucracy)
		8. Voluntary efforts through organizational sponsorship, e.g., YMCA, Boys Clubs, Big Brothers, etc.

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
I. Social-Political: (cont)		9. Construction of responsible roles in community organization and governance for young people
J. Philosophical: (General and Personal)	Search for purpose and meaning in life Organization of experience into a belief structure Search for personal identity Creation or change in values and philosophical lifestyle Overcoming frustration from lack of meaningful vocation and work	1. Seminars, workshops on values and meaning of life (adults) 2. Courses on values, ethics, morality, meaning, etc. (schools) 3. Reading philosophical literature 4. Values clarification procedures; identify clarification procedures 5. Exposure to philosophical (non-violent) aspects of martial arts, e.g., aikido and karate 6. Exposure to metaphysical literature and thought 7. Humanistic counseling oriented toward meaning and values clarification 8. Achievement values, from meaningful challenge from career or employment 9. Exposure to individuals committed to varieties of personal philosophies 10. Creation of community "growth centers" 11. Maximization of ethnic, racial and minority pride

Level of Experience: Type of Gratification	Corresponding Motives, Needs Aspirations	Alternative Example
K. Spiritual-Mystical:	Desire for intense spiritual experience, often labeled "higher levels of consciousness" Desire for specific mystical states, e.g., "enlightenment," communication with God, etc. Overcoming frustration with organized religion Augmentation of unorthodox spiritual methodology, e.g., yoga, meditation Pertaining to the experience of a guiding philosophy of life, an explanation of the universe; also personal identity, including goals, purpose, and values	1. Study of spiritual literature; increased library holdings relevant to non-chemical spiritual methods 2. Creation of information centers for spiritual alternatives 3. Exposure to holy men of different belief systems; exposure to different techniques of applied spirituality 4. Meditation 5. Yoga (especially non-physical components) 6. Contemplation and prayer 7. Spiritual dance and song 8. Increased course offerings in intellectual and experiential components of spiritual study (especially college level and secondary level)
L. Miscellaneous:	Need for risk-taking, danger Need for adventure, exploration "Vacuum phenomenon" or "What else is there to do?" Economic Profit	1. Sky-diving, scuba-diving, etc. 2. "Outward Bound" survival training 3. Exploration of new physical environments, e.g., flying, soaring, camping in wilderness areas, etc.

Level of Experience: Type of Gratification	Corresponding Motives, Needs Aspirations	Alternative Example
L. Miscellaneous: (cont)	Combination of motives, needs, aspirations - none of which individually would produce drug abuse, but do — in a cluster Need to react to extreme mental or physical discomfort, e.g., as in the maintenance of narcotic addiction, or in extreme psychological pain and/or confusion	4. Competence of "self-reliance training", e.g. vocational and occupational education, instruction in household technology (i.e., autos, electronics, plumbing, household appliances, etc.) 5. Family management education i.e., accident prevention, childcare, money management first aid, menu and diet planning, etc. 6. Vocational counseling leading to meaningful employment 7. Credited work experience through schools, e.g., house-building, merchandising, service station maintenance, restaurant training, etc.

GETTING STARTED

For the concerned individual, school officials or representatives of agencies of the community who wish to initiate a more alternative based program in their sphere of activity, some helpful hints might include the following.

1. Know what you hope to accomplish. Make your values, expectations and goals explicit. Are they reasonable? Too ambitious? Credible?

2. Know whom you want to assist. What is the target population? If you cannot appeal to everyone, who are your priorities?

3. Understand the target population. If the population is using drugs or favorably disposed toward them, why? What satisfactions are being sought? If you don't know, ask. Conduct surveys, interview your subjects in confidential and empathetic surroundings. Find out what is most likely behind the drug use patterns. Your task is to find the most relevant levels of experience from the population and fit the alternative's emphasis to their needs, not the converse.

4. Survey current resources. Get comprehensive information on the pre-existing drug programs which are affecting the target group. Discover other alternative-oriented programs in your area, even if they are not directly connected with the drug problem. Interview non-users and find out what they have gotten interested in and why.

5. Involve the target population in planning. Try not to impose an alternative approach on anyone; use the talents, resources and opinions of the target group as a guide for implementation. Let them become involved; this itself is a potent alternative.

6. Get political know-how. Be aware of the political and bureaucratic situation affecting possible programs. Try to enlist the support of important community forces.

7. Use the drug abuse issue to assist implementation. You may opt for alternative approaches which directly affect the underlying needs for drugs, the conditions which nurture drug abuse. These may be controversial so you may do well to intorduce your program as an anti-drug abuse program. Unless your approach has inherent weakness or unacceptability, it is difficult to resist well planned innovation billed as drug abuse intervention.

V. Alton Dohner, M.S., M.D. states:

> At a time when Americans are crying for ways to decrease drug experimentation, illegal drug use, abuse of legal and illegal drugs, and some existing drug dependence, too little has been done about offering alternatives. These non-chemical alternatives to drug abuse and drug dependence can be offered to young and old by existing social institutions such as schools, churches, recreation centers and the family. Too often, unfortunately, the family has abrogated its responsibility to society at large.
>
> My basic philosophy is that there are visible, positive, alternatives to drug use. These alternatives can minimize adverse consequences, escalation to stronger or more dangerous drugs, and recruitment of others into the scene. These alternatives can maximize involvement, the quality of life and the life experience and the responsible use of potentially toxic agents. Involvement with any of the alternatives listed can produce a new state of consciousness for the user and an improved sense of worth.
>
> Courses dealing with expansion of personal awareness, improved interpersonal relations, increased esthetic appreciation, development of creative abilities, human sexuality, and self-reliance development can be offered by schools, community colleges, adult education centers, and universities. There should be no numerical or letter grades given. Who can adequately judge the relative worth of a very personal experience or expression without interjecting his own value system or attempting to force acculturation? The major emphasis should be giving information to assist in making personally meaningful value judgements and career decisions.
>
> Developing many of these alternatives will entail expenditures for space, materials and instructors. However, many school buildings are unused 50-60% of the time and many individuals in the community would enjoy teaching occasionally if asked. Our society must decide which is more important: providing alternative opportunities or increased rates of absenteeism, hospitalization and drug dependence, increased welfare and child support payments, increased numbers of crimes against persons and swelling prison rolls, and thousands of wasted lives.

Most of all, these alternatives require sincere, interested individuals who are willing to put out a hand and say "Let me show you something better". Are we human beings less able to do this than are other members of the animal kingdom?

SPECIFIC EXAMPLES OF ATTAINABLE ALTERNATIVES

THE REAL WORLD -

This alternative is a high school course taught by Norman J. Sweeney, Superintendent, Chenango Forks Central Schools. The goals of this course are to:

1. Help each student realize his potential
2. Help the student plan to utilize this potential to the maximum
3. Provide information that will help each student survive in the real world.
4. Develop each student's appreciation for the free enterprise system
5. Help students realize that the USA is still the "land of opportunity"

The course includes field trips to Albany to: attend a meeting of the legislature, visit with a legislator, lobby for a certain bill, visit state agencies, etc. Students go to New York City to visit the Stock Exchange, U.N., World Trade Center, etc. They visit colleges (a variety of 12 campuses), industries and related job center, a funeral home, banks, etc.

Class projects include organizing and administering a school blood pressure screening, a community blood drive, a Consumer Hotline, etc.

Individual projects include: spending a day in the career field of your choice, volunteering five hours of service in the Career Lab, visiting a car sales room and outlining the steps necessary in purchasing a vehicle, visiting a nursing home, working on a local or national election, visiting a crisis center, etc.

COURSE DESCRIPTION - REAL WORLD SEMINAR

I have been asked to design and teach a course to members of the junior class during the winter trimester.

The subject matter will pertain to some of the many social problems that a person is likely to be faced with at some point in life. Studies indicate that during the past fifteen years there has been a significant increase in the amount of Americans that are having difficulty in handling every day life problems. Present estimates from authorities indicate that one out of three people in our society will require some type of psyco social counseling by the time they are eighteen (18) years of age. Some examples of this include:

1. Increase in alcoholism especially among teenagers and women.
2. Increase in the amount of drug users to the point where it has reached epidemic proportions. In 1962 , only 1 % of youth ages 12-17 and 4% of young adults 18-25 had ever used marijuana. By 1979 , these figures had risen to 31% and 68%.
3. While our nation as a whole is getting healthier (life expectancy has now grown to 73 years), statistics indicate that Americans aged 15-24 are dying at a 15% greater rate than they were in 1960. The three leading causes of death in this age group are:
    a. Accidents
    b. Suicides
    c. Homicides

There are many areas of life that one needs to prepare for while he or she is in the formative years.

I think it would be helpful for a student to know more about the following:

1. Identification by individual of what he or she believes the components of love are. How does one use love in every day life?
2. Aging Problem and Rewards

   We grow a little bit older every day we live. Somehow in the past twenty years we have managed to separate younger Anericans (less than 18) from older Americans (over 60).

   This has deprived each of these groups of the special energy and wisdom of the other.
3. Deliquency in Youth

   The constant problem behaviors of our young people that society labels as deviant needs to be looked at and discussed. Where can a troubled teenager go for counseling or problem solving assistance?

4. Alcoholism

The amount of alcoholism in our society increases year by year. I would like to discuss with the students the various ways alcoholism is diagnosed and treated. Perhaps, in looking at the behavior of an alcoholic, the student can identify **himself and** others certain behaviors that need to be addressed.

5. Criminal Justice System

Many young people get involved with the criminal justice system because of a lack of knowledge of the law. Drug use, alcohol use, running away from home, poor driving habits, and shop-lifting are some examples of this.

How and why the law acts and reacts to such behaviors could bring about a better understanding of the criminal justice system and hopefully an increased respect for it.

The primary objective of these discussions would be:

a. Increased awareness by the student on some of the problems s/he will be faced with in the future.

b. The strategies and techniques one may consider when dealing with such problems will be identified.

c. Identification of possible resources a person can utilize if a problem should occur.

d. A better understanding of the way society looks at the problem areas that are discussed.

e. Identification of some life coping skills that could be developed in the teenage years and be useful in later life.

    1. Problem solving ability
    2. Self-Image
    3. How to get along with others

METHODS:

Each subject area would be discussed for two (2) sessions. Session one would be mainly a feed in from the instructor and invited guests. The guests would be people from society who were dealing with the particular problem area being looked at. Session two would be mainly feed back from the student. The students' attitudes and values would be compared to the attitudes and values of society in general in regards to the subject area. Clarifications of the problem and ways to handle it would be done in session two by using small group dynamics.

COURSE OUTLINE

1. Loving and Living

Session One - identification of what the components of love are and how one uses love in every day life.

Session Two - feedback from class in groups and as individuals on the subject - perhaps a student hand-in.

2. Aging Problems and Rewards

Session One - Lecture from an "Older American" (60+) on his/her life experiences with a special emphasis on emotional and physical health.

Session Two - Student feedback and optional hand-in

3. Deliquency in Youth

Session One - Lecture from an individual who has done some work with deliquents. Emphasis on some of the constant problems and behaviors troubled teenagers have.

Session Two - How such problems could be dealt with - Identification of resource people and friends we could use to help solve serious problems.

4. Alcoholism Treatment

Session One - Discussion from a person who runs a treatment program. Emphasis on teenagers in treatment. How they sat there. How they got helped.

Session Two - How to identify a "high risk" person who may become alcoholic. This will deal with physical and emotional characteristics.

5. Criminal Justice System and Youth

Session One - Who controls it. What are rules of members of it.

a. Judge
b. Policeman
c. District Attorney
d. Probation

PEER PROGRAMS

There are many types of peer programs, some more economical than others. Some of the cream of the crop are contained in this manual.

TYPES OF PEER PROGRAMS

PROGRAM	EMPHASIS
Positive peer pressure	
Elementary school level:	
Magic Circle	
Ombudsman	
Tribes	
Secondary Level:	
SPARK	
PEDE	
Operation Snowball	
Low Income-oriented:	Group Interaction
Positive Peer Culture	
Gang Programs	
Health-specific	
Houston smoking prevention program	
Stanford smoking prevention program	
Say No	
Peer Teaching	
Youth Tutoring Youth	
Jigsaw	
Teen Involvement	
Programs with Health-related Content	Information
Teenage Health Consultants	
Planned Parenthood Programs	
Peer Counseling/Facilitating/Helping	
Palo Alto peer counseling program	
Student service centers	Youth in helping relationships
Gainesville, Florida, peer facilitator program	

PROGRAM	EMPHASIS
Peer Participation	
Something More than Survival	Youth empowerment and responsibility
Channel One	
Urban Youth Teams	
Youth Action Teams	
Three O'clock	

HOW PEER PROGRAMS FUNCTION

THE ROLE OF THE STUDENT

Minimal
youth participation
and responsibility

Maximal
participation
and responsibility

Class listening to lecture	Class works together in small groups	Peer counseling program	Positive peer pressure program	Peer participation program
Adult A	Adult B	Adult C	Adult D	Adult E

Maximal
adult dominance

Minimal
adult dominance

THE ROLE OF THE ADULT

THE COMPLETE HANDBOOK OF PEER COUNSELING

An authoritative guide, by Mimi and Don Samuels, for the organization, training, implementation and evaluation of a peer counseling program for educators, counselors, trainees, trainers and facilitators. This book specifically describes exactly how to do it, step by step. It provides an up-dated, easy reference and modern approach towards training people to help other people through Peer Counseling. Price $5.95

Fiesta Publishing Corp.
Educational Books Division
6360 N.E. 4th Court
Miami, Florida 33138

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21 WAYS TO SAY "NO!"

Peer pressure is now recognized as a focus of disciplinary and drug/alcohol abuse problems among young people. This pamphlet provides practical suggestions for youths who want to turn down negative proposals from their peers concerning unwanted drinks and drugs, but who don't know how to handle such situations. The suggestions made are good natured, often light-hearted and amusing, but may help any young person into clearer thought about his personal decisions. The thought is to help such persons to realize that they do not need to "go along" with ideas they do not favor. They can say "no" and they can do it avoiding a quarrel and preserving personal dignity. 100 copies - $27.50 postpaid. Additional 100's - $15.00.

Order from:

Grafton Publications, Inc.
667 Madison Ave.
New York, NY 10021

REACHING OUT

A book by Gerald Edwards which addresses the prevention of drug abuse through increased human interaction. The intent of this book is to deal directly with the emotional, societal and school-related causes of drug abuse in young people. The book focuses directly on what the teacher and the students are doing that is different from the traditional classroom setting.

Teacher objectives include to:

1. establish a climate in which students can interact with one another and with the teacher.
2. constructively channel and facilitate free verbal and non-verbal expressions of thoughts and feelings.
3. give students skills training in active listening, creative thinking and honest expression of thoughts and feelings.
4. provide opportunities for young people to accept their own thoughts and feelings as well as those of others.
5. heighten the student's awareness of himself and his relationship to his social and physical environment.
6. provide activities to broaden the student's ability to experience his environment.
7. provide experiences which will foster the growth of a student's positive self-image.
8. assist students in developing decision-making skills.
9. develop an environment in which the student can explore and test his own reality concepts.
10. provide experiences for students that help them distinguish between propaganda and fact.
11. prepare students to utilize learnings by providing experiences that stimulate inquiry and encourage them to actively, skillfully, and independently seek and utilize information for the betterment of self and society.

FAMILY WORKSHOPS

Six family workshop sessions have been completely developed utilizing "Parents and Problems" by Dr. Fred Streit. The materials include: trainer instructions for everything from logistics to session schedules and activities, recruiting procedures, training exercises, take-home pamphlets, completion certificates, and evaluation tools.

Master trainers from your organization will receive two or three days of training to implement the system and then they are qualified to recruit family trainers. Master trainers train family trainers to recruit in the neighborhoods and to conduct family workshops.

Recent studies have shown that, if parents or adolescents receive training separately, there appears to be change in attitudes without any concomitant changes in behavior. When the sessions include both parents and their adolescents together, positive behavioral changes occur in the family.

Thus, the Family Workshops discribed here involve parents and their adolescents recruited and participating in sessions together in their own neighborhoods using validated, research-based designs and materials.

The six sessions are:

Session I - Through the Eyes of Youth

Providing an understanding of how adolescents perceive their parents and the impact on adolescent behavior and problems.

Session 2 - Do My Parents Understand Me?

Providing an understanding of the physical and psychological development of adolescents.

Session 3 - But They're My Friends

An exploration of the peer group and its role in relation to parents and adolescent social development.

Session 4 - Do My Parents Love Me?

An examination of how people perceive love from others and, especially, how love is communicated between parents and adolescents.

Session 5 - The Sexual Adolescent

A factual examination of the myths of adolescent sexual behavior. This session does not deal with standards for sexual behavior or clincial examination of sexual practice. It deals with the myths and facts of adolescent sexuality.

Session 6 - Why Can't I do What I Want?

An examination of the methods and outcomes of parental disciplinary techniques. Procedures are used to have parents and adolescents explore alternatives at home.

Pamphlets which cover each of the individual topics are available. They are designed to be read by parents of adolescents and provide a research based approach for the prevention of delinquency, runaways, alcohol and drug abuse problems.

Session 6 (cont.)

They may be sent home to parents via students as a way of stimulating intra-family discussions or given personally by guidance, pupil personnel services, teachers, and administrators to parents who have problems with their adolescents.

The pamphlets may be ordered from:

Essence Publications
168 Woodbridge Avenue
Highland Park, New Jersey 08904

Order Quantity	Price Per Copy
1-5	1.00*
6-10	.75
11-50	.70
51-100	.65
101-500	.60
501-1000	.55

*Note: For quantities of 1 to 5 copies, payment must accompany the order. Essence Publications will pay the postage and handling costs.

ADOLESCENT WORKSHOPS

In order to help you train others to know more about the adolescent, Essence Publications has introduced the *Adolescent Workshops*. The manual now available for sale is almost trainer-proof and requires only that you designate someone on your staff with teaching or training skills to implement it. The *Adolescent Workshops* manual contains the necessary schedules, exercises, research references and reinforcing pamphlets to implement the seven 2½ hour sessions.

All seven sessions are about adolescence, are based on research and are devoid of opinions, directions or "how to". While the sessions build upon each other, they do stand alone and, after the first one, can be used separately. The *Adolescent Workshops* system has been prepared for use with:

Teachers, counselors, administrators and paraprofessionals in public and private schools.

Parents through PTA, PTO and other volunteer agencies.

Youth workers, police juvenile officers, probation officers.

Attached is a description of the seven sessions currently contained in the manual.

The complete *Adolescent Workshops* training manual and material is available to you at a cost of $30.00 plus shipping costs. We are unable to offer examination copies at this time. However, we do offer a money-back guarantee if you are not satisfied with the manual.

To receive your copy of the *Adolescent Workshops* manual, send a purchase order or letter to:

ESSENCE PUBLICATIONS
158 Woodbridge Avenue
Highland Park, New Jersey 08904
(201) 572-3120

If payment accompanies the order, you may deduct five (5%) percent ($1.50) and we will pay the UPS charges.

Descriptions of the seven sessions currently contained in the Adolescent Workshops manual are:

Session 1	Through the Eyes of Youth Examines how adolescents perceive their parents and other adults and the impact on adolescent behavior. This session provides the basis for the remaining sessions.
Session 2	I Don't Have Two Parents at Home While adolescent problems are highly associated with the "broken home," the evidence is that it is still what the single parent does that makes the difference-and not just whether the home is broken or intact.
Session 3	Do Adults Understand Me? Provides an understanding of the physical and psychological development of adolescents.
Session 4	But They're My Friends The peer group is placed in appropriate perspective providing an understanding of peer group influence and its control.
Session 5	Do You Care About Me? Few people will argue about the human need for caring and affection. There has been little research which examined how children and adults perceive affection and caring from others. This session provides insight and experience into the area of giving and receiving caring and affection.
Section 6	Adolescent Sexuality Adolescence is the time of awakening sexual interest, identity and activity. This area is clouded with myth and confusion. The session provides insight into adolescent sexuality, adult concerns and adult roles.
Session 7	Why Can't I Do It My Way? A most frustrating and difficult area for parents and other adults is the administration of discipline. Some adults use power, others use withdrawal of affection, and some use reasoning. This session provides information related to alternate ways of using discipline as well as sources of problems.

PARENTING PROGRAMS

While Dr. Thomas Gordon's PET (Parent Effectiveness Training) is the most visible and "popular" parenting approach, there are many other psychological theories that have been applied to the problems of being a parent (e.g., discipline, teaching decision-making or values, communicating, etc.) PET is dominantly the application of Carl Rogers' theory to parenting.

STEP (Systematic Training for Effective Parenting) was developed by Dinkmeyer and McKay and is based on Dreikurs' theory (e.g., learning from natural and logical consequences, family meetings, etc.) It is available from the American Guidance Services.

Behavioral contracting has been applied to parenting and MacIntyre's *For Love of Children* is a good example of this program. A sample of behavioral contracting received at the Annual New York State Health Education Conference in Rochester, December, 1981 follows this page. It may be applied to a multitude of drug related behaviors protrayed by students in your school system.

SAMPLE CONTRACT

SAMPLE B

BEHAVIOR	GIVE	GET	MEASURE OF CHANGE
Behavior student would like to change. The behavior to be addressed must be specific and in measurable terms.	Strategies and commitments by client or group to address specifically identified behaviors.	Support and commitment of staff to assist with identified strategies. This area of the contract identifies what the client would like the service provider to do.	What will constitute success or failure.
Example: Poor Academics	The group commitment to do homework and attend class regularly.	The staff will establish a peer tutoring program. The staff will meet with individual teachers who may be supportive towards participating in the contract. This will be done on a request basis.	Passing grades (65%) in all but one subject area. Shoot a little under to insure success.
Example: Truancy	Clients will explor their reasons for not going to school. Clients will attend all regularly scheduled group meetings.	Staff will explore the group's reasons for going to school. Staff will provide rewarding experiences. Staff will suggest alternative behaviors.	Student attendance (by days) will be better during the contract period than the comparable time prior to contract period. Ex: 15 weeks

CONTRACT SHOULD BE WRITTEN BY PARTICIPANTS AND SIGNED TO ATTEST TO ITS ACCURACY. THE CONTRACT SHOULD BE POSTED IN THE COUNSELING AREA.

SAMPLE B-1

SAMPLE CONTRACT

BEHAVIOR	GIVE	GET	MEASURE OF CHANGE
Behavior student would like to change. The behavior to be addressed must be specific and in measurable terms.	Strategies and commitments by client or group to address specifically identified behaviors.	Support and commitment of staff to assist with identified strategies. This area of the contract identifies what the client would like the service provider to do.	What will constitute success or failure.

CONTRACT GRID

SAMPLE A

May have several behaviors dealing with one condition all going on at the same time.

		01		02		03		04		05		06		07		08		09	
PRESENT BEHAVIOR	EXPECTED CHANGE	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C
DRUG ABUSE/ ABUSE	REDUCED SUBSTANCE USE																		
TRUANCY	IMPROVED ATTENDANCE																		
SMOKING	REDUCED SMOKING																		
CUTTING CLASS	IMPROVED ATTENDANCE																		
DEAN'S REPORTS	FEWER REPORTS																		
FIGHTING	LESS AGGRESSIVE BEHAVIOR																		
POOR ACADEMICS	IMPROVED ACADEMICS																		
OTHER/ SPECIFIC																			

PURPOSE:

TO DEMONSTRATE THAT CONTRACTING CAN BE EFFECTIVELY USED TO MEASURE BEHAVIOR

ASSESSMENT:
I= IMPROVED
NC= NO CHANGE
R= REGRESSION

KEY:
B= BEHAVIOR
C= CHANGE
0-1 STUDENT 1
0-2 STUDENT 2
consecutively to 0-9

PROCUDURE:

1. Identify target population.
2. Intake and screening of client(s). (Complete Contract Grid)
3. Develop contract.
4. Conduct group sessions addressing the motivation for identified behaviors and in line with the group contract.
5. Measure degree of change based upon the contract (15 weeks).

(Contract grid serves as a guide for teachers. It shows areas of weakness (i.e., changes in all areas except drug abuse reduction may mean the teacher hasn't enough knowledge about drugs...or it's an area not covered sufficiently).

TO BE SUBMITTED AT THE END OF CONTRACT PERIOD

SUMMARY:

1. No. of clients ________
2. No. of behaviors ________
3. Measure of Change
   I=
   NC=
   R=

CONTRACT GRID

SAMPLE A

May have several behaviors dealing with one condition all going on at the same time.		0 1		0 2		0 3		0 4		0 5		0 6		0 7		0 8		0 9	
PRESENT BEHAVIOR	EXPECTED CHANGE	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C	B	C
DRUG ABUSE/ ABUSE	REDUCED SUBSTANCE USE	X	I	X	NC	X	I											X	
TRUANCY	IMPROVED ATTENDANCE			X	I	X	I					X	NC	X	I				
SMOKING	REDUCED SMOKING					X	R									X	I		
CUTTING CLASS	IMPROVED ATTENDANCE							X	I										
DEAN'S REPORTS	FEWER REPORTS									X	I								
FIGHTING	LESS AGGRESSIVE BEHAVIOR																		
POOR ACADEMICS	IMPROVED ACADEMICS											X	NC					X	
OTHER/ SPECIFIC																			

PURPOSE:

TO DEMONSTRATE THAT CONTRACTING CAN BE EFFECTIVELY USED TO MEASURE BEHAVIOR

ASSESSMENT:
I= IMPROVED
NC= NO CHANGE
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KEY:
B= BEHAVIOR
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0-2 STUDENT 2
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PROCUDURE:

1. Identify target population.
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4. Conduct group sessions addressing the motivation for identified behaviors and in line with the group contract.
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(Contract grid serves as a guide for teachers. It shows areas of weakness (i.e., changes in all areas except drug abuse reduction may mean the teacher hasn't enough knowledge about drugs...or it's an area not covered sufficiently).

TO BE SUBMITTED AT THE END OF CONTRACT PERIOD

SUMMARY:

1. No. of clients 9
2. No. of behaviors 14
3. Measure of Change
   I= 8
   NC=3
   R= 3

14 Total

Biofeedback

Biofeedback means giving a person immediate ongoing information about his or her own biological processes or conditions, such as heart beat, temperature, brain waves, blood pressure, or muscle tension. Information is usually "fed back" by a physiological record as it emerges from the monitoring equipment. Biofeedback training involves using the information to voluntarily change or control the specific process or response being fed back.

The American Lung Association of Central New York has biofeedback equipment available for loan during feedback programs related to smoking.

D.O.P. - DIMENSIONS OF PERSONALITY

This is a packaged series of values - oriented material with an emphasis on the individual's interaction with the material. The original D.O.P. series consisted of six reading books, one for each of the first six grades of school (1-6). Each reading book is accompanied by a practitioner's (teacher's) manual and group activity sheets. To the original elementary material, kindergarten/primary, junior high, and senior high level programs have been added. The series deals with such issues as feelings, self-image, emotional, intellectual, physical, and social development, personal inquiry and searching for one's values. It involves communication by the student with his family as well as teachers and peers. It is available from CEBCO-Pflaum, Division of Standard Publishing.

First Grade - Now I'm Ready

1. Meeting People
2. Making Friends
3. Getting to Like School
4. Being More Awake (Senses)
5. Using My Muscles
6. Growing and Changing
7. Trying New Things

Second Grade - I Can Do It

1. Coming Back to School
2. Controlling My Body
3. Thinking About My Feelings
4. Solving Problems
5. Making Plans
6. Making Others Happy or Unhappy
7. Choosing For Myself

Third Grade - What About Me?

1. I Belong Here
2. I'm Somebody Special
3. My Feelings Are Me
4. Who's Afraid
5. I Feel Mean
6. I Like Me
7. Becoming Me

Fourth Grade - Here I Am

1. Getting to Know Myself
2. Knowing I'm Alive
3. How Do I Know It's Morning
4. My Feelings Are Real
5. The Body I've Inherited
6. The World Around Me
7. How Different Are We
8. I Always Behave Myself
9. When I Cried For Help
10. My Mirrors
11. What A Difference A Year Makes

Fifth Grade - I'm Not Alone

1. The Family Group
2. The Play Group
3. The Classroom Group

Sixth Grade - Becoming Myself

Emotion

1. Finding My Feelings
2. Speaking Without Words
3. How I Feel Now
4. My Feelings Are Divided
5. Learning Where I Stand
6. Learning To Be A Friend
7. Living With Me
8. I Don't Like Me
9. If I Dislike Myself
10. Hiding Myself
11. What The Mirrors Show

Growth

12. My Physical Growth
13. My Emotional Growth
14. My Growth Into Adolescence
15. My Social Growth
16. My Intellectual Growth
17. I'm Still Growing

Developing Human Potential

Volumes One and Two by Robert C. Hawley and Isabel L. Hawley are designed to give to teachers and other group leaders specific activities to use for the following purposes: First, to develop the creative potential of their students; Second, to help young people become more aware of their own totality of being - of their impact on other people and things and upon themselves, and of the nature and extent of outside influences and forces which shape their lives; Third, to help young people to take conscious control over their lives so that they can become more effective as persons; Fourth, to combat the spectator-consumer psychology which is so prevalent in today's culture.

The workshop approach is used in both volumes. Teachers have permission of the authors to duplicate materials. Some activities can be adjusted for any level, but most fit into the middle school level.

Developing Human Potential is available from:

ERA Press
Education Research Associates
Box 767
Amherst, Massachusetts 01002

Education In Human Behavior

The purpose of this series of handbooks for grades 1-6 is to supply materials and suggestions to assist the teacher in developing a series of learning experiences for teaching a causal orientation toward human behavior and the social environment.

This program has clear objectives and ways of measuring these objectives by the teacher. The pupil assumes increasingly greater amounts of responsibility for guiding his own development. The handbooks use indepth explanation of behaviors and their causes.

"The main concern of the *Learning* to *Decide* program is that children learn a *method* that will enable them to make creative and life-enhancing decisions in the area of moral values." The accent is on *how* the child makes decisions - the methods he uses.

Education in Human Behavior is available from:

Educational Research Council of America

HUMAN RELATIONS EDUCATION: A Guidebook To Learning Activities

Teaching young people to respect the rights of others is more than the job of the school teacher. Parents, clergymen and church workers, club advisors, neighbors, employers, union leaders - all must have a hand in this most important task facing Americans today.

While this book should be useful to many of these people, it is primarily addressed to teachers. It is not a course of study to be taught instead of the regular school curriculum, although some of the lessons in it may give more meaning to topics in which the teacher may not have seen a human relations theme. The grade levels indicated tell the user what age of children are most likely to enjoy the suggested activities - and acquire something worthwhile from them.

The learning activities for elementary school children are identified only as for primary or intermediate grades. At the secondary school level, five subject matter fields are used to show the classes in which some teachers think the lessons might be useful, but the suggested activity might even be more effective for a teenage club. The questions listed are just suggestions that some teachers found helpful; the user may wish to word them differently, putting them into the words in which young people may say them.

Human Relations Education is available from:

University of the State of New York
The State Education Department
Curriculum Development Center
Albany, New York 12224

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D.U.S.O. - Developing Understanding of Self and Others

This is a child focused learning program for teachers of K-6 grade levels, developed by Don Dinkmeyer, Ph.D., and published by the American Guidance Service, Inc. Its goal is to help children understand social and emotional behavior through inquiry, experimental learning and discussion. The techniques which are outlined and packaged clearly for the leader's use include: puppets, reading suggestions, music, art and others. The material is organized thematically and can be used in any combination daily throughout the school year. Basic themes are: self-identity, friendship, resourcefulness, competence, emotional stability, and responsible choice making. The kit includes a manual, puppets, cassettes, posters, activity cards, and discussion guides. The package is purchased in kit form.

Kit I and Kit II are available for examination through:

Cortland-Madison BOCES

- -

Character Education: Handbook for Teachers

According to Valley Forge Military Academy: "The most urgent problem of modern education is not technical - it's ethical."

This program uses case studies followed by questions to help the participant focus on values. There are case studies for each discipline: Religion, Athletics, Social Studies, Mathematics, English, Foreign Language, Science.

The philosophy behind this program is based on the thoughts of Herbert Spencer, an English philosopher. Spencer says "Education has as its object the formation of character." The Academy feels that in order to form character the "primary goal is that of educating the whole man - developing his mental, physical, spiritual, and social values and his individual potential."

Character education would be best taught in a horizontal approach - one using all disciplines.

The Academy also feels that "the school has not met its obligations if in the educational process the student has not been provided with the environment and the opportunity for the examination of values, the selection of principles, and the determination of right choices." It order for this to be accomplished "the philosophy and objectives of the school, the commitment of the staff and faculty, the structure and nature of the curriculum, and student attitude must be in harmonious coordination."

HUMAN DEVELOPMENT PROGRAM, PRE-SCHOOL TO SIXTH GRADE, HUMAN DEVELOPMENT TRAINING INSTITUTE, 1727 FIFTH AVENUE, SAN DIEGO, CALIFORNIA 92101

OVERVIEW CHART

HUMAN DEVELOPMENT PROGRAM
Levels, Group Arrangements, Strategies, and Objectives
Grades Pre-School through Six

LEVEL	GRADE	AGE	GROUPINGS	STRATEGIES	OBJECTIVES
Pre-school		4-5	Single Circle 5-10	Encouragement to talk, listen, succeed.	Improve self-control and ability to listen and express; develop self-confidence and understanding of interpersonal interaction. Tolerance for individual differences. Understanding of universalization principle - emphasis on common human feelings, thoughts and behavior. Increase self-acceptance and listening skills. Begin coping with mixed feelings.
Kindergarten		5-6	Single Circle 8-10	As above. Deal with negative as well as positive topics.	
I	First	6-7	First one circle 8-12; then add self-controlled children to outer ring until whole class is in two concentric rings. Teacher and child leaders alternate.	As above. Discuss 1) ambivalence in feelings, thoughts, behaving, 2) effective and ineffective behavior, 3) reality and fantasy. Discuss variables of inclusion, exclusion, warmth, coldness, making of decisions. Begin leadership experiences.	As above. Effective self-control, ability to comfortably experience ambivalence, improve reality testing, self-confidence, effective meeting of needs, increase responsibility, tolerance, empathy, skill in making helpful suggestions. Sharing dec. making and recognition of leadership abilities.
II	Second	7-8	As above.	As above. Continued presentation of methods of awareness, coping, social interaction. Character development is fostered by challenge, commitment, and direct interpersonal communication with peers.	As above. Articulation of wide range experiences in positive and negative feelings, thoughts and behavior. Self-confidence and positive self-concept. Ability to distinguish between reality and fantasy. Motivation to be responsi productive, kind, Share in decision-making.

HUMAN DEVELOPMENT PROGRAM

Levels, Group Arrangements, Strategies, and Objectives (continued)

LEVEL	GRADE	AGE	GROUPINGS	STRATEGIES	OBJECTIVES
III	Third	8-9	As above.	As above. Further challenge to self-sufficiency, integration, honesty. Emphasize responsibility in social interaction, keeping commitments.	As above. Self-control as a matter of personal pride. Verbal facility, skillful and tolerant listening. Ability to tolerate ambivalent feelings in self and others. Skill in observing differences between verbalization and performance. Wise decision-making and responsible, constructive leadership. Courage in taking the initiative to build good social relationships.
IV	Fourth	9-10	As above.	As above. Role playing. Micro Lab. Experiences with authenticity and duplicity, exploring dreams and practice at problem solving.	As above. Accepting and reflective listening. Deeper self-awareness and understanding of social relationships. Fuller acceptance of responsibility for one's own behavior.
V	Fifth	10-11	Three general plans for articulation, presented.	As above. Focus on importance of flexible outlook and behavior. Units no longer assigned to a certain number of days of the week. Supplemental affective activities presented in a variety of subject areas.	As above. Increased understanding of how trusting relationships are developed. Awareness of the complexities in social situations. Development of a sense of identity. Dealing with role expectations. Increasing awareness of one's own capabilities and likeable qualities.
VI	Sixth	11-12	As above.	As above. Focus on responsibility for one's own behavior. Increased supplemental affective activities presented in a variety of subject areas.	As above. Increased self-confidence through validation of self and others. Increased sense of self identity and group dynamics. Exploring conflict resolution. Increased understanding of self-determination, choices and decision-making.

Circle of Warmth

Circle of Warmth has relatives and roots. It's a family program and also a member of a family of programs! This family is known as the Human Development Program. Well known "sister" programs to Circle of Warmth are the Magic Circle Program for children ages 4-12 , Innerchange for teenagers in junior and senior high, and Customized Management Training for adults.

Putting these theories and ideas into a nutshell, the Human Development Program has three "roots."

The first and most basic root is Awareness, one signle word which holds numerous meanings. Circle of Warmth seeks first to enhance your acknowledgment of many things: The feelings, thoughts and actions of the members of your family and how they interplay. Stronger family ties and individual personalities are built on increased insight, knowledge and understanding.

Social Interaction is the second root. Humans are social beings - almost always surrounded by other humans. For this reason, it is very important for us to learn how to interact with one another effectively and to develop empathy.

Besides aiming to increase your Awareness, Circle of Warmth offers numerous suggestions for ways you and your family can become more caring of one another. The activities give you enjoyable opportunities to practice positive communication habits - to speak clearly and listen carefully to one another. This is the basis for warmth within your family.

The third root from which Circle of Warmth grows is called Mastery (getting good and knowing it). Circle of Warmth aims to help you find the strength you already have within you to become an effective family manager. It also encourages you to become self-confident and self-loving by providing information and the chance to practice effective interpersonal skills.

When you are aware and knowledgeable, able to relate effectively to the members of your family, and supportive of yourself, you've got what it takes to spark and maintain family harmony. With these assets and your own determination your family can achieve a strong feeling of oneness.

Circle of Warmth is another product of:

Human Development Training Institute
1727 Fifth Avenue
San Diego, California 92101

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Innerchange: A Journey Into Self Learning Through Group Interaction

Why Innerchange? By Geraldine Ball

Innerchange is the name of the Human Development Program (HDP) at the secondary level. It is the product of a rich and exciting history which began in 1964 when Uvaldo Palomares, Harold Bessell and I decided one evening to write a book. Dr. Bessell was a psychotherapist in private practice, and Dr. Palomares and I were educators. Essentially, our book was going to tell teachers that they should carry out small-group discussions in the classroom in order to help students maintain their mental health.

We believed at the time (and still do) that by sharing their thoughts and feelings in group discussions, students would find out how alike we humans are and, at the same time, how unique. By this process, we hypothesized, they would also learn positive communication skills. Further, we believed that the discussions would allow the students to explore verbally important content that relates to life itself.

This content grew out of Dr. Bessell's observations of his clients in therapy. He noted that every troubled individual either seemed to be 1) unaware of him/herself as a feeling, thinking, behaving individual (and unaware of this triad of functioning in others), 2) lacking in self-confidence and self-respect, or 3) unable to interact effectively with other people. Very often, clients had problems in more than one of these areas. These observations were consistent with the myriad literature available in the field of psychology. It was particularly interesting to us that these problems seemed to affect various people in general, regardless of their socioeconomic status.

Turning these difficulties into their positively stated counterparts, we decided that the content for the classroom group discussions should aim at increasing students' 1) awareness of self and others, 2) self-confidence (or sense of mastery), 3) skills at social interrelating. Succinctly stated, the three growth areas became known as Awareness, Mastery, and Social Interaction.

What is Innerchange And How Do I Use It?

Innerchange is an educational process, and a curriculum designed to allow people beyond the age of 11 to learn more about themselves and others. It uses a confluent approach to synthesize the cognitive and affective domains and it concentrates on contemporary issues such as career education, substance abuse, crime prevention, values exploration, human relations, and multicultural and multiethnic understanding. While innerchange utilizes a wide variety of activities, its prinipal mode is verbal interaction which allows students and teachers (or counselors) to explore their humanness together.

Interchange comes in the form of a package - or rather, four packages - as follows:

- complete Innerchange package for educators at the junior high level
- complete Innerchange package for educators at the senior high level
- Innerchange Workshop Starter Kit for educators at the junior high level
- Innerchange Workshop Starter Kit for educators at the senior high level

The complete junior and senior high Innerchange packages are the same with respect to format. They both come in a colorful box. The contents include:

- instructional units
- an Innerchange Experiences book
- a Leader's Manual

The junior and senior high complete Innerchange packages differ with respect to content. The junior high package includes 41 instructional units and the senior high package includes 44. The Innerchange Experiences books also differ at the two levels. While some of the units and Innerchange Experience Sheets in both packages are similar none are exactly the same.

The program is also available from:

Human Development Training Institute
1727 5th Avenue
San Diego, California 92101

Project Sunshine

For the past 6 1/2 years, I have been directly involved with the drug, alcohol, and mental health fields. I have worked primarily with dysfunctioning adults, attempting to help them change their behavior so they could become productive members of society. Not only was this many times a frustrating experience, but it left me searching for a better answer. Suddenly it became apparent that human beings do not become sick and dysfunctional over night. In most cases, it's a long process taking sometimes years and years. Once this became obvious to me, I investigated those individuals I was working with and discovered that almost exclusively their negative behavior began early in their adolescent years. Before adolescence, however, they were relatively healthy, trying desparately to like themselves and to function in the way they thought was expected of them. So, what then became even more obvious to me, was, why not step in while these individuals are still healthy and use a little preventative medicine. That's what Project Sunshine is all about: Prevention. Helping a child to maintain his good feelings about himself before he turns to drugs, alcohol, or dysfunctional behavior to do it for him.

Project Sunshine: A warm, growing experience! Grades K-4

Sylvia Pfannenschmidt
Education Prevention Specialist
Community Counseling Services, Inc.
130 N. Walnut Street
Bucyrus, Ohio 44820

PROJECT SUNSHINE RULES

1. Listen - Take your turn. Raise your hand. Only one person talks at a time. We show respect for each other by listening to each other.
2. No Put-Downs - No teasing, laughing at, making faces at any member of the group. This will be a rule strictly enforced.
3. Observe Your Space - No touching, kicking, bothering anyone in the group. Keep in your space.
4. Right To Pass - If you don't feel like answering a question, you don't have to, simply say pass!

SOME DO'S AND DO NOT'S FOR THE LEADER

1. Don't pressure a child into answering or ask him why he has chosen to pass.
2. Don't show favorites with certain students. Children pick up quickly on favortism.
3. Don't allow the teacher to "bring you up to date" on who has been especially bad this week or who to keep an eye on. This will prejudice you.
4. Don't allow one child to dominate the discussions.
5. Don't attmept to help a child to do something an "easier" or "better" way.
   This will be your values coming through and you will be hindering learning and creativity.

****

1. Do participate in the activities. This will show the students you are relating to them and make them feel much more comfortable.
2. Do go by Mr. and Mrs. except perhaps when the teacher may go by her first name. By using your first name, you will be looked upon more as a friend than a teacher. A teacher could also feel threatened by this or in competition with you.
3. Do hold the class to the alloted time.
4. Do smile and , above all, be warm and honest!

TRIBES: A Process For Peer Involvement

How The Tribes Program Was Born

For a long time many schools and agencies in California had been seeking methods to prevent behavior problems. Concerned teachers, parents, counselors, and administrators had been groping for new ways to prevent vandalism, alcohol and drug abuse, and to reduce the high drop out rates in high schools. Traditionally, approaches to the prevention of these problems meant controlling behavior by laying out rules and punishments, instilling fear of authority, and withholding privileges.

In September, 1972 the staff of the Contra Costa County Drug Education Center began to turn the question around. We all agreed that prevention does not happen by controlling others...but by transferring to others the responsibility to take care of themselves. (We needed a program that would help children and youth develop their own inner resources and responsibilities. We needed a program that would develop a positive environment, conducive to learning and emotional development.)

At Last-The Grand Plan (Using a student named Mark as an example)

Having considered the classroom environment, academic learning needs, and the profile of young people with behavior problems, we were certain that our program needed to give Mark membership in a peer group that would affirm his unique value over an extended period of time. The positive regard stated regularly by his peers could enhance his self-image far more than occasional "strokes" from his teacher. (Just think how hard it is for any well-meaning teacher to give everybody stokes each day!) We wanted the group to become a small classroom family whose support would enhance Mark's learning ability and emotional development. The group would be in his tribe so that Mark no longer had to fight for inclusion or act out to gain attention and influence.

The important three R's of relating, respect, and responsiblity would all be experienced in his tribe in a natural flow of activities facilitated by Mark's teacher. As his group developed a sense of trust and inclusion with each other, it could give Mark practice in asserting his individuality in the midst of his peers. Repeated experiences of respect from other members could enable him in the teen years to stand up in the midst of a negatively-oriented group and say, "I feel differently about that than the rest of you. I'm no going to drop reds or cut class. I'm going to act on my own and not be influenced by all of you."

In time, Mark's tribe would work cooperatively together in the curriculum of the academic three R's; and they would become responsible to each other for carrying out agreements about tasks and personal behavior.

Tribes (cont)

The big "plus" is that Mark's teacher no longer would have to do it all by herself, but would count on four or five tribes in his classroom to make teaching much easier. She would become an expert and sensitive facilitator of small groups that provide a supportive environment for growth and learning. She would finally have a classroom management system that relies upon positive peer power rather than adult authority.

Tribes is available from:

Jeanne Gibbs and Andre Allen
Center-Source Publications
166 Capricorn Avenue
Oakland, California 90611

The Quest Program

The core of the Quest Program is the Skills for Living curriculum and the companion book for students, You Are Somebody Special. The materials are based on a survey of over 2,000 high school students designed to determine their ten most pressing concerns. These ten major responses are areas of concern dealt with in the curriculum, as well as the total Quest Program.

The prime focus of the curriculum is on practical methods by which students and parents learn basic skills in problem-solving, communication, increasing self-esteem, and conflict resolution. These skills are then applied to the ten areas of concern indentified in the survey.

The program is based on the belief that all students can benefit from learning these basic skills and applying them to each of the ten identified concerns. These areas of concern comprise the unit titles of the Skills for Living curriculum, SELF-CONCEPT, FEELINGS, ATTITUDES, FRIENDS, FAMILY, MARRIAGE, PARENTING, MONEY, CAREERS, PHILOSOPHY.

The Quest Program has four primary components which facilitate the teaching of Skills for Living. These four components are: TEACHER TRAINING WORKSHOPS AND FOLLOW-UP SUPPORT, COURSES FOR TEENAGERS, INTERNSHIPS FOR STUDENTS, SEMINARS FOR PARENTS.

The primary focus is to help secondary students increase their feelings of self-esteem and develop life skills in the areas of: DECISION-MAKING, CITIZENSHIP, INTERPERSONAL COMMUNICATION, RESPONSIBILITY, MOTIVATION, ATTITUDES, SELF-DISCIPLINE, GOAL ACHIEVEMENT, PROBLEM-SOLVING.

Quest may be ordered from:

Quest, Incorporated
2707 N. Main Street
Findlay, Ohio 45840

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TEEN INVOLVEMENT FOR DRUG ABUSE PRESENTION

The National Institute on Drug Abuse has developed Teen Involvement, a program for involving youth in drug abuse prevention activities in their school and local communities. It aims at preventing substance abuse by utilizing positive youth-to-youth communications. Junior and senior high school students are trained to present the "Why" and the "What can be done about it" messages to students in grades four through twelve.

Teen Involvement's objective is to develop improved decision-making capabilities and better organized values in order to reduce and prevent substance abuse among youth. This process works and takes effect as youth spread the word that not using drugs or alcohol is the "in thing" to do. Thus, selected students, or Teen Advisors, serve as role models or a collective "in group" for younger students. These older students refer to themselves as the "real group." Teen Advisor training is designed to enhance and improve the communications skills of each Teen Advisor and to provide them with the latest training techniques in primary prevention. After carefully supervised training they visit elementary school classrooms on a regularly scheduled basis.

A copy of "The Administrator's Guide" and "Training Manual for Students" may be obtained from:

The Prevention Branch
Division of Resource Development
National Institute on Drug Abuse
5600 Fishers Lane
Rockville, Maryland 20857

HUMAN RESOURCE COORDINATOR

The following are excepts from "A Concept Paper" by Ronald J. Gaetano, P.Ph. for Wyoming Seminary. It represents one school's approach.

Concept:

There is a great need for an alternative for students, teachers, and parents within high schools to express concerns and discuss problems, this alternative being the Human Resource Coordinator. This concept is a new and innovative approach to drug and alochol prevention for schools. When a student is faced with a problem, in most cases, where does he turn? Parents? Teachers? Conselors? We have found that a small percentage of students who have problems are willing to open up and discuss these problems with school personnel and even fewer with parents. More often than not, it is friends to whom they turn, who sometimes have the same information or sometimes more and often times less, and frequently, in the course of discussing the problem, those thought to be friends become non-friends through arguments over solutions and/or alternatives. The Human Resource Coordinator becomes the option, or alternative source of information and referral. For the Dean of Students, it allows for outside, independent and objective viewing of concerns and problems within the school, but not related to school authority. For counselors, it is a non-threatening instant source for referral of students whose problems are beyond their scope or out of their area of expertise. For teachers, it also offers the referral source and information not readily available to them within the school. For parents, it offers a special service in that they can ask to see the consultant and not have to deal with school authorities when concerns or chemical problems arise with their college-age children. For the student, it offers a non-threatening, unbiased and confidential source with whom they can talk and, in turn, be more inclined to discuss abuse problems or chemical concerns, which otherwise would be held in and possibly lead to more troublesome problems. The Human Resource Coordinator approach to the prevention aspect of chemical abuse brings to the school, the openness needed to attract the concerned and troubled, be they the school personnel, community interests, parents or, most importantly, students.

The Human Resource Coordinator

The Human Resource program is envisioned as a comprehensive abuse prevention program which faces the challenge of youthful addiction by strengthening youth before the decision of abuse presents itself. At its inception the H.R.C. Program will reach adolescent students in one high school in the areas of prevention, early intervention and referral for drug and alcohol abuse problems.

The H.R.C. approach of outreach to students is based on the fact that drug abuse almost always occurs in the context of other social and emotional problems. It takes into account the general need of every person to know how he or she can affect or be affected by drug and alcohol abuse. More specialized attention will be given to those students who have already established patterns of drug abuse , or who give evidence of being high risk for drug abuse or other negative behavior that result in poor academic and disciplenary performance in school. The program seeks to meet the needs of each student, and the needs of the school as a whole, by coordinating efforts between students, teachers, and parents.

A comprehensive program, such as the H.R.C. Program is urgently necessary as demonstrated by our school community and the community at large. We feel the H.R.C. Program is the best organization to handle these problems because we have directives and attitudes that allow us to operate within the existing school system. Working with, but separate from the school, we have the advantage of influencing the student in an environment where he spends from 33 to 50% of his weekly time. By law the adolescent is mandated to attend school. This gives us the advantage of influencing the greatest number of students. The legal confidentiality of school records gives us the best opportunity to guide the student with the added advantage of protecting his good name and reputation.

The H.R.C. Program also provides the added opportunity of coordinating the efforts of students, teachers and parents in the custom-made program which meets the needs and sensitivities of that particular school. Operating within the school, the H.R.C. Program also provides the means by which peer group pressure, one of the most influential elements in adolescent development, can be used to its greatest advantages. In this school environment the problematic student is most visible and behavioral progress or regression can be continuously monitored so that consistent and appropriate remedies can be provided. It is logical that the student would be more responsive to seeking help in an environment which is familiar and where such assistance is readily available.

Another point to be considered is that in the school situation, the H.R.C. Program will be able to take advantage of an attitude and system of education already established that would make the imparting of knowledge with regard to abusive behavior less difficult.

Goals:

1. To decrease drug and alcohol abuse behavior and to prevent youth from becoming involved in drug abuse or alcohol abuse through programs of education, counseling and leadership training.

2. To expand services of screening, referral for more intensive intervention and follow-up for youths whose drug abuse patterns indicate need for specialized help.

3. To initiate positive attitudinal development and value awareness in youths which will provide them with a basis from which the social and psychological factors leading to drug and alcohol abuse can be maturely handled in a decision making process.

Goals: (cont)

4. To provide youth with drug alternatives and avenues for personal growth through programs offering free time activities, community service opportunities, and supportive peer group environment.

5. To increase the knowledge and awareness of the general community concerning drug abuse and drug related social and psychological problems and solutions.

Objectives:

1. A mechanism for self-sustaining core group of at least one percent of the student body and some faculty representatives will be established.

2. At least 20% of the student population will become involved in small group activities designed to develop self awareness, communications kills, and decision-making ability.

3. Participants in personal development groups will evidence a stronger control over their lives, increased self esteem, and a more positive outlook on their own personal potential.

4. Increased services will be received by students seeking help to deal with problems related to the effects of alcohol abuse within the family.

5. Referrals for students in need of intensive physical, psychological or social service will be arranged and followed through by the program's prevention specialist.

6. A smoothly functioning network of cooperation among the shcool, Mental Health Center, and other treatment services will be established.

7. As a result of consultation and educational services provided by the program specialist, teachers and school officials and parents will be better prepared to reach students whose acting-out behavior is symptomatic of other underlying problems.

DIVERSION PROGRAM

The philosophy of a diversion program at Wyoming Seminary, Kingston, Pennsylvania, is simply to offer to administration and the student offender a method that will allow what is a negative experience to become part of a positive growth process. The diversion program is an alternative process that will allow the student to remain in school rather than dismissed and sent back to a family which may be angry and confused by the behavior of the student and the action taken by the school administration.

The proposed benefits of a diversion program are:

1. The student will have a school based counselor working with him/her on an ongoing basis.

2. During the time the counselor and the student will be allowed to discuss his or her feelings about the siutation in a confidential manner. This certainly is an advantage to the recently used system that suggested to the student that his/her only option was to express regret for his/her actions and make a promise to "sin no more".

3. Many students who have disciplinary problems want counseling but are afraid of peer pressure if they seek help. The diversion program is initiated by school officials and is something the offender is told to do, thereby freeing the student of put downs by peers.

4. The diversion program will be broken down in various segments that will be designed to allow the student to look at spiritual, emotional, and physical self. If one knows that a certain behavior (drinking) will not be condoned by the school, then certainly feelings must control the act. What feelings are there that need to be discussed so that the student can understand why he or she has behaved in this manner? The student and counselor then can look at alternatives that will be more beneficial and acceptable to all parties who are concerned.

5. The diversion program will provide a reasonable time frame for faculty and administration to think about what to do with a student who has committed an offense. This takes away a great deal of stress that is present when a decision to act is done in a crisis oriented manner (he did this--we have to do something right away).

The diversion program will cover the following points:

1. Self image - a self image test will be given to the student and will be discussed in depth.

2. Values, attitudes and behavior will be covered in another session. Responsible behavior will be explained and clarified for the student.

3. Goals and objectives will be set toward which the counselor and the student will work.

4. The benefits and risks that the offending act brings about will be discussed.

5. Any problem the student discloses to the counselor will be evaluated and a plan of how to help the student with that problem will be implemented.

The five sessions that the diversion program presently has are:

1. Introduction of counselor and student and explanation of why each is involved in the program.

2. Self image profile given and discussed.

3. Examination of student attitudes, values and behavior

4. Alternatives to present problems and negative behavior (how the counselor can help the student meet his or her needs in a way that does not hurt others).

5. Evaluation by student of the time spent in diversion program. Evaluation by the counselor of the present frame of mind of the student.

During the time the student is in the diversion program the counselor will keep the Dean of Students informed on such matters as are necessary. This includes such information as:

1. Student attendance at sessions.

2. Attitude of the student.

3. The continuation of the diversion program - student or counselor's choice.

4. Suggestion for alternate plan should the relationship between student and counselor be unproductive, including recommendation that the student be dismissed from school in the case of a serious offender who is being uncooperative with the counselor

While the diversion program is set up for student offenders, it will not be limited to just that group of people. Any student may be invited to or volunteer for such a program. The series allows for a flexible goal oriented approach to a student with problems to enter into.

The major thrust is to provide a setting to the troubled student that allows for personal growth.

DRUG OFFENDERS DIVERSION PROGRAM

A good example of this program can be found in California. Drug possession offenders are removed from conventional criminal prosecution channels into programs of education, treatment or rehabilitation. For the first three years, almost 85% of these divertees successfully completed their programs and had their charges dismissed.

A California Supreme Court statement clearly sets forth the two-fold purpose of the States' diversion program:

1. Diversion permits the courts to identify the experimental or tentative user(before he becomes deeply involved in drugs) to show him/her the error of his/her ways by prompt exposure to educational and counseling porgrams in his/her own community, and to restore him/her to productive citizenship without the lasting stigma of a criminal conviction.
2. Reliance on this quick and inexpensive method of disposition, when appropriate, reduces the clogging of the criminal justice system by drug abuse prosecutions and, thus, enables the courts to devote their limited time and resources to cases requiring full criminal processing. Cortland County Schools' Itinerant Drug Counselor could be used for such a program.

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"I QUIT KIT"

This is a self-help stop smoking program from the American Cancer Society. It involves a step-by-step approach to working on a person's smoking habit at his/her own pace in the privacy of his/her own home. It is available at not cost at:

The Cortland County Unit Office
25 Clinton Avenue
Cortland, NY 13045
(756-2277)

FREEDOM FROM SMOKING

A new two-part series filled with specific activities designed to help a person to understand his/her smoking habit better... so that the person can learn to stop N O W!!!

The manuals were developed by specialists...doctors, psychologists... people who really understand the smoking problem. It took four years and a quarter of a million Christmas Seal dollars to develop and test the manuals. Therefore, to help defray the cost of printing and handling a $5.00 contribution is suggested...less than the cost of a carton of cigarettes.

The American Lung Association of Central New York has many other excellent materials and programs which you may wish to investigate. Call (315) 422-6142.

An order form for FREEDOM FROM SMOKING is included here for your convenience.

Please send me _______ copies of FREEDOM FROM SMOKING.

PLEASE MAKE CHECKS PAYABLE TO:

AMERICAN LUNG ASSOCIATION OF CENTRAL NEW YORK

AND MAIL TO:

- -

AMERICAN LUNG ASSOCIATION OF CENTRAL NEW YORK
POST OFFICE BOX 6409 (2013 E. GENESEE STREET)
SYRACUSE, NEW YORK 13217

NAME: ______________________________

ADDRESS: ______________________________

______________________________ ZIP CODE ______________

AMOUNT ENCLOSED: $______________

THANK YOU!!!

COMMUNITY AGENCIES AND SERVICES

The following listing covers the counseling services and existing programs in the areas of drugs, alcohol and tobacco available to the residents of Cortland County at this writing. It is designed to serve as a quick and ready reference for school personnel and may be copied and given to parents who request guidance on where to turn in the community for help.

ALCOHOLICS ANONYMOUS

P.O. Box
Cortland, New York 13045
(607) 753-1344

This program serves males and females of all ages. The emphasis of the program is peer guidance through the sharing of experiences and life philosophy. Esatablishing a feeling of fellowship and positive self concept.

FEE: - Personal Contribution

The 12 Steps of A.A.

1. We admitted we were powerless over alcohol - that our lives had become unmanageble.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make ammends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

(The 12 Steps of A.A. - cont)

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The 12 Traditions of A.A.

1. Our common welfare should come first, personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. A.A. should remain forever non-professional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. A.A. has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of our traditions, ever reminding us to place principles before personalities.

AL-ANON

(607) 756-6048

Services provided for adults who are relatives or friends of alcoholics.

FEE: - None

Practical Do's and Don'ts for spouses who are confronting a co-existence with a problem drinker for the first time.

WHILE WAITING FOR A "RIGHT TIME"

DO

Try to remain calm, unemotional and factually honest in speaking with the problem drinker about his behavior and its day-to-day consequences.

Let the rpoblem drinker know that you are reading and learning about alcoholism, attending Al-Anon or Alateen, and the like.

Discuss the situation with someone you trust-a clergyman, social worker; a friend, or some individual who has experienced alcoholism either personally or as a family member.

Establish and maintain a healthy atmosphere in the home, and try to include the alcoholic member in family life.

Explain the nature of alcoholism as an illness to the children in the family.

Encourage new interests and participate in leisure-time activities that the problem drinker enjoys. Encourage him or her to see old friends.

Be patient and live one day at a time. Alcoholism generally takes a long time to develop and recovery does not occur overnight. Try to accept setbacks and relapses with calm and understanding.

Refuse to ride with the alcoholic person if he insists on drinking and driving.

DON'T

Attempt to punish, threaten, bribe, preach, or try to be a martyr. Avoid emotional appeals which may only increase feelings of guilt and the compulsion to drink.

Allow yourself to cover-up or make excuses for the alcoholic person or shield him from the realistic consequences of his behavior.

Take over his responsibilities, leaving him with no sense of importance or dignity.

Hide or dump bottles, or shelter the problem drinker from situations where alcohol is present.

Argue with the alcoholic person when he is drunk.

Try to drink along with the problem drinker.

Above all, do not accept guilt for another's behavior.

ALATEEN

(607) 753-7672

Services provided for students aged 12-18 who are relatives or friends of alcoholics. Students meet with other teens with the same problem.

For transportation call 749-4073.

FEE: - None

Alateen's Do's and Don'ts

Do's

1. Do remember you are not the only one with an alcoholic parent.
2. Do look for help in Alateen, Al-Anon, AA, and other local and community councils on alcoholism.
3. Do learn all you can about alcoholism, a family disease.
4. Do be honest with yourself and others.
5. Do use your talents in ways that interest you.
6. Do develop a sensible attitude about alcoholism.
7. Do remember that not only the alcoholic, but all the members of the family are emotionally involved with disease.
8. Do find someone other than a relative that you can confide in.
9. Do learn to forgive yourself and others - you only hurt yourself by holding grudges.
10. Do keep your trust in your Higher Power.
11. Do take your own inventory and admit your faults to one person.
12. Do pass on your knowledge of Alateen to others.

Don'ts

1. Don't make it easy for the alcoholic by covering up for him and taking on his responsibility.
2. Don't try to make the alcoholic stop drinking - you can't. Only he can.
3. Don't argue with an active alcoholic.
4. Don't hide or throw out his liquor; he will only buy more.
5. Don't take it personally when the alcoholic blames you for his drinking - he'll use any excuse.
6. Don't use drugs or alcohol as a means of escaping the problem.

ALCOHOLISM SERVICES - CORTLAND COUNTY

County Court House
Cortland, NY 13045
(607) 753-0213

Contact Persons:

George J. Griffith, Jr., Director
Andrew Bennett, Counselor

Information, referral and treatment. Individual counseling, medical resources and outreach.

FEE: - Sliding scale; contact the agency

AMERICAN CANCER SOCIETY

Cortland County Unit
25 Clinton Avenue
Cortland, NY 13045
(607) 756-2277

Contact Person:

Diane Dorset, Executive Director

Has excellent educational materials in the area of tobacco education, smoking cessation. Will conduct cessation clinics and educational programs in the schools.

FEE: - None

AMERICAN LUNG ASSOCIATION

of Central New York, Inc.
2013 E. Genesee Street
Syracuse, NY 13203
(Ask Operator for Enterprise #9069 no charge)

Contact Person:

Jeffrey Berman, Executive Director

Offers exceptional materials in the area of tobacco eduction and smoking cessation.

Will conduct cessation and educational programs in the schools and run training for the Seattle and Berkley Projects.

FEE: - None, except for the last projects mentioned and they will help schools set up fund raisers to help cover the costs of these.

CITY YOUTH BUREAU-YOUTH SERVICES DIVISION

23 Court Street
Cortland, NY 13045
(607) 753-3580 (after 2:00 P.M.)

Contact Person:

Cicele Beladoff

Services provided for students aged 13-18. Counseling, information, education, referral, services for drugs and alcohol, in-school discussion group.

Parents of adolescents discussion and support group being planned.

Peer Counseling.

Schools can make referrals

CORTLAND COUNTY MENTAL HEALTH CLINIC

60 Central Avenue
Cortland, NY 13045
(607) 756-7523 (Emergency Phone - same number)

Contact Person:

Jan Cozort

Individual, group and family counseling services on an outpatient basis for all age groups, both male and female.

Alcoholism and multiple substance abuse service provides help for those persons who misuse and abuse these substances.

FEE: - sliding scale - Meidcaid and participating private insurance accepted.

CORTLAND COUNTY COUNCIL OF CHURCHES

Calvert Street
Cortland, NY 13045
(607) 753-4002

Contact Person:

Rev. Walter Parry

This program functions for all age groups male and female. It provides ministry, counseling and referral.

FEE: - None

JUVENILE AIDE BUREAU

54 Greenbush Street
Cortland, NY 13045
(607) 753-3311

Contact Person:

Gary Contri

Criminal Complaints - The Juvenile Aid Officer answers criminal complaints involving males and females 15 years of age and under.

Community Education - Drug Education classes are taught during regular office hours and on occasion, after hours. Target population is school aged children in Cortland County.

FEE: - None

VOLUNTEER FAMILY COUNSELING SERVICE

36 Main Street (above Marine Midland)
Cortland, NY 13045
(607) 753-9349

Youth Assist: Contact person -Margaret Cahill

Volunteer counselors provide informal counseling services to males and females between the ages of 9 and 18. Can be referred by schools. Transportation can be provided.

Family Counseling: Contact person -Robert Gardner

Counselors work with parents and children regarding family problems.

Interim Family: Community residents provide temporary housing for displaced youth aged 13-17.

Drug Counselor: Early intervention counseling of youth involved with chemical substances. Schools are encouraged to refer students and/or their families.

The drug therapist is responsible for providing drug counseling and referral services to the individual. Assessments will be made in the areas of nutrition, vocation, education, family planning, living accomodations, and legal assistance. At the time of admisssion, the person must demonstrate a history of drug dependence or be in immediate danger of becoming dependent because of repeated use of a substance.

THE WHO'S WHO

ON

ALCOHOL, SMOKING & DRUGS

A RESOURCE GUIDE

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  - 3. Kit
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  - 3. Films/videotape
  - 4. Games

- C. Drugs
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PRIMARY LEVEL RESOURCES

SMOKING

Pamphlet

"Why Nick the Cigarette is Nobody's Friend"
Children's Bureau PU Number 447-1966

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Books:

"The Story of a Cigarette"
by Lindsay R. Curtis, M.D.
(Coloring Book) - FREE

American Cancer Society
25 Clinton Avenue
Cortland, NY 13045
756-2277

"Kathy's Coloring Book About Drugs and Health"
(Coloring Book) - 35¢ per copy

National Clearinghouse for Drug Abuse Information
5600 Fishers Lane
Rockville, Maryland

Films:

"Adventures of a Man In Search of a Heart" - BOCES 831-71
6 min. c p

The Tin Woodsman presents positive preventive approach to taking care of the heart - nutrition, exercise, no smoking. Animated. An American Heart Association Film.

"Heart That Changed Color" - BOCES 831-430

9 min. c P-I

Further adventures of the Tin Woodsman in the land of Nicotine. Even Queen Nicotine comes to realize that smoking is no joke. An American Heart Association Film.

"Huffless, Puffless Dragon" - BOCES 831-392
8 min. c P-I

Uses humor and satire to emphasize health hazards of cigarette smoking. An American Cancer Society Film.

PRIMARY LEVEL RESOURCES

ALCOHOL

Books:

"My Dad Loves Me, My Dad Has a Disease"
A workbook for children of alcoholics by Claudia Black
Cost - $7.00

Published by ACT
P.O. Box 8536
Newport Beach, CA 92660

Films:

The films for this level unit do not deal directly with the chemical, but rather with feelings and handling them.

Feelings/A Series - BOCES
8-10 min. ea. P

I'm Feeling Alone	831-395
I'm Feeling Sad	831-396
I'm Feeling Scared	831-397
I'm Mad at Me	831-398
I'm Mad At You	831-399

These filmed experiences help children to talk about and understand their own feelings.

PRIMARY

DRUGS

Books:

"Becky's Book about, Drugs and good health"

National Child Safety Council
Jackson, Michigan 45204

"Kool Kat- Rapping With You On Drugs"

Laura Productions Inc.
210 Fifth Avenue
New York, NY 10010

Souzie says "Only Sick People Need Drugs"

The Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

Films/Filmstrip/Videotapes:

A DAY WITH BILL COSBY - VO-00339
48 min. c P-I

Videotape presents comedian Bill Cosby and drug experts Father Egan, Jon Stuart Mars and Ulysses Williams explaining the dangers of drug abuse to children.

DRUGS: A PRIMARY FILM 831-346
9 min. P-I

Familiar situations are used to explore the correct use of drugs. Emphasizes the positive attitudes needed for a rich and healthy life.

DRUGS, POISONS & LITTLE CHILDREN 392-4
15 min. P

Filmstrip designed to provide an introduction to the placement of medicine and drugs in young people's lives. Poisons are shown and discussed to reinforce the concept that to ingest, sniff or taste an unknown substance can be deadly.

SNIFFY ESCAPES POISONING 831-336
6 min. P

Gives an effective warning about the dangers behind the medicine cabinet door. Speaks to the very young in a language they can understand. A very first film for drug education.

CHART/KIT:

Smoking Flip Chart CH-4 P BOCES

From the American Cancer Society, uses rabbits as the main characters and discusses the effects and dangers of cigarette smoking. The chart also comes with basic concepts and suggested activities.

Smoking Lung (HIRC) BOCES 123-35

White plastic sponges that resemble air sacs in the lungs discolor as they "Smoke a cigarette.

PERIODICAL:

"The Winner" - Narcotics Education Services
6830 Laurel St. N.W.
Washington, DC 20012

This magazine helps guide elementary school aged children into a lifestyle free from destructive dependence.

Published September - May

BOOKS FOR ELEMENTARY STUDENTS

An excellent resource: The Bookfinder Volumes 1 and 2, a guide to children's literature about the needs and problems of youth aged 2-15. American Guidance Service.

Anglund, Joan	A Friend is Someone Who Likes You	Harcourt/Brace
Anglund, Joan	Love is A Special Way of Feeling	Harcourt/Brace
Bach, Richard	Jonathan Livingston Seagull	MacMillan
Berger, Terry	I Have Feelings	Behavioral Pub.
Fassler, Joan	One Little Girl	Behavioral Pub.
Fassler, Joan	The Boy With a Problem	Behavioral Pub.
Freed, Alvyn	T.A. for Tots	Jalmar Press
King, Robin	The Angry Book: My ABC's of Mean Things	Norton, NY
Krementz, Jill	How it Feels When a Parent Dies	Knopf, NY
Little Twirps	Understanding People Book Series	Ages 3-7
Little Twirps	This is My Opinion About Creative Thinking Workbooks (Readers have an opportunity to write their answers).	
Lobel, Arnold	Frog and Toad Series (Ages 4-8)	Harper & Row
Schleim, Miriam	The Way Mothers Are	Whitman Chicago
Seuss, Dr.	My Book About Me	Random House
Silverstein, Shell	The Giving Tree	
Spilke, Francine	What About Me: Understanding Your Parents' Divorce	Crown Pub.
Stren, Patti	Hug Me	
Vogel, Ilse-Margaret	The Don't Be Scared Book	Atheneum Press
Williams, Giveneira	Timid Timothy	Scott, Foresman, & Co. NY 1944
Wondriska, William	All By Myself	Holt, Rinehart, Winston, NY
Wright, Betty	This Room is Mine	Whitman Chicago
Zolotou, Charlotte	The Hating Book	Harper & Row NY
Zolotou, Charlotte	Janey	Harper & Row
Zolotou, Charlotte	William's Doll	Harper & Row

RECORDS FOR ELEMENTARY STUDENTS

For more information: Salenger Educational Media, 1635 12th St., Santa Monica, California 90404.

Free to be You and Me	Marlo Thomas, Bell Records, NY
Getting to Know Myself	Hap Palmer, Activity Records, NY
You Are Special	Mr. Rogers, Small World Records
I Wish I Were	Mr. Rogers, Small World Records
Songs for Children With Special Needs	Collected by Frances Cole Bowman
Won't You Be My Friend	Marcia Berman, Activity Records, NY

INTERMEDIATE LEVEL

SMOKING

VIDEOTAPE:

"Smoke Screen"
5 min. I VO-00144

Aims to deter children from acquiring the smoking habit through the use of kinestatic images of smokers.

PAMPHLET:

No Smoking: Lungs at Work
American Lung Association of Central NY
2013 E. Genesee Street
Syracuse, NY 13217

BOOKS:

Dying to Smoke - by Robert Osborn and Fred Beutum
(BOCES)

First Step - Amy Snyder
(BOCES)

FILMS/FILMSTRIPS:

BARNEY BUTT 832-277
13 min. IJS

The heart and hard times of a comical cartoon character from infancy through teenage adventure, smoke blighted romance, short-winded attempts at sports, failure at work. An American Heart Association Film.

"CIGARETTE SMOKING - TAKE IT OR LEAVE IT"
10 min. I 392-18(BOCES)

Filmstrip, record, four transparencies, and teacher's guide. Produces decision making framework for investigating health choices. American Cancer Society - producer.

HUFFLESS, PUFFLESS, DRAGON 831-392
8 min. I

Uses humor and satire to emphasize health hazards of cigarette smoking. American Cancer Society Film.

SMOKING - IT'S YOUR CHOICE 832-414
15 min. I-J

Scientific demonstrations show that the effects of smoking don't wait... they start with the first puff. Not always pleasant to watch, it is persuasive as it explains the adverse effects on the respiratory system.

SMOKING & CHILDREN 392-1
30 min. I

Kit deals with the history of tobacco use and the effects smoking has on various parts of the body. Filmstrip included.

THE DRAG 831-151
8 min. I (BOCES)

Animated approach to the decisions people make about smoking. Without preaching shows some of the motivations to stop.

"TAKE JOY" 833-2020
10 min. I (BOCES)

Situation: Children playing and come across pack of cigarettes - reactions. Film shows how the body's system replenishes itself without harmful pollution.

MEDIA KIT:

SMOKING LUNG (HIRC) BOCES 123-35

White plastic sponges that resemble air sacs in the lungs discolor as they "smoke" a cigarette.

INTERMEDIATE LEVEL RESOURCES

ALCOHOL

WORKBOOK:

My Dad Loves Me, My Dad Has A Disease

A workbook for Children of Alcoholics
by Claudia Black

Published by: ACT
P.O. Box 8536
Newport Beach, CA 92660

BOOKS:

Kids & Alcohol by Peter Finn and
Jane Lawson (BOCES)

Kids & Drinking - Ann Snyder (BOCES)

The Long Ride Home - James L. Summers
(BOCES)

One Day At A Time - Regina Woods (BOCES)

FILM/FILMSTRIP:

ALCOHOL & CHILDREN 392-2
30 min. IJ

Filmstrip discusses the history of alcohol, the various kinds of alcoholic beverages and their uses and also the effects alcohol has on various parts of the body. Filmstrip ends with a discussion of why people drink alcohol either occasionally or chronically.

UNDERSTANDING ALCOHOL - USE OR ABUSE
IJ 832-612

The facts that children need on alcohol are presented in an informative, but non-threatening way. Animated.

INTERMEDIATE

DRUGS

PAMPHLET:

"Drugs - You? Survivor's Handbook" 25¢ each

Ed-U Press
760 Ostrom Avenue
Syracuse, NY 13210

BOOKS:

Twelve Is Too Old by Peggy Mann $7.95 each

(first novel on the pot scene for teens and pre-teens)

American Council on Marijuana
767 5th Ave.
New York, NY 10022

What You Should Know About Drugs

Charles Gorodetsky & Samuel Christian

DRUGS AND CHILDREN 392-3
30 min. IJ

This kit contains two filmstrips. The aim of this program is to inform students of the history and sources of various drugs; the contributions of drugs and medicines to human health and life; and to help students realize that drugs are potent agents that have potential harm if misused.

DRUGS AND THE NERVOUS SYSTEM 832-88
18 min. I

Explains the serious disruption of the nervous system caused by drugs: glue, stimulants, depressants, marijuana and LSD. Animated (Rev. Ed.)

DRUGS: THE FIRST DECISION 831-261
9 min. IJ

Young people are encouraged to look for positive alternatives to drug exploration and to participate in some critical decision making of their own to avoid the dangers of "turning on".

ME, MYSELF...AND DRUGS

(Sound Filmstrip) Guidance Associates

INTERMDIATE

INTEGRATED PROGRAMS

BOOK:

What Makes Me Feel This Way BOCES
Eda LaShan (about feelings)

Films/Filmstrips:

ALMOST EVERYONE DOES 832-122
14 min. IJ BOCES

Shows the different ways many people try to change the way they feel by taking something. It could be alcohol, nicotine, marijuana, barbituates, or it could be heroine. Suggests that there are alternatives to drug use and encourages one to use his feelings - good ones and unhappy ones.

Brothers, Sisters, Feelings and You.

Sound Filmstrip Guidance Associates

EXPECTATIONS 832-427
14 min. c I BOCES

Thematically grouped excerpts from TV special, FREE TO BE YOU AND ME. A mini-course in self-awareness.

FRIENDSHIP AND COOPERATION 832-426
16 min. c I BOCES

Thematically grouped segments from the TV Special FREE TO BE YOU AND ME. A mini-course in self-awareness.

HEALTH WRECKERS 832-416
13 min. I-J BOCES

Introduction to the health threats posed by alcohol, drugs, and smoking. Key information is presented and reinforced with images designed for retention and recall. Good discussion starter.

I AM 832-231
14 min. I BOCES

To promote a discussion on the formation of a self-concept and about feelings.

INDEPENDENCE 832-428
17 min. c I BOCES

Thematically grouped segments from the TV special FREE TO BE YOU AND ME. A mini-course in self-awareness.

I THINK 832-120
19 min. I-J

Dealing with pressures from various sources and that one's most significant act may well be the day one listens to the voice within that asserts: This IS What I Think!

TELL IT LIKE IT IS

Six books with filmstrips & records

New York Council on Alcohol Problems
1690 1/2 Western Ave
Albany, NY 12203

Cost of all $49.85 Individually $10.95

Titles:
1. LSD - Trip or Trap
2. Alcohol - Fun or Folly
3. Glue - sniffing - Big trouble in a tube
4. Smoking or Health
5. Lets talk about Goofballs and Pep Pills
6. Why Not Marijuana

WHAT ARE PARENTS FOR?

2 sound filmstrips Guidance Associates

ELEMENTARY SCHOOL DRUG COMMITTEE SIMULATION GAME

By Jan Eustis

This simulation game was created for sixth graders to be used after a drug education unit which looks at the motivations and reasons for drug abuse. The purpose of the game is to draw together concepts and action. The conceptual analysis of causes of drug abuse is useless unless it can be put into practical terms.

The game is very simple. Time limits and expectations should be made very clear, as this is often a new experience for children.

Before the game starts, there should be a review of the causes of drug abuse, based on:

idle time
peer pressure
human needs - sources of good feelings

It should be explained that they will be trying to prevent drug abuse, therefore they must consider the reasons for it.

An explanation of simulation games and what "role play" is are important. Group size: 23 (approx.). Time: 40 min. (minimum). Situation: You are all citizens of a small town like your own. Nobody thought there was a drug problem here until 2 weeks ago, when the police busted 5 high school students for smoking marijuana. You are now looking at ways to solve the problem of drug abuse. This is a meeting of 4 community groups with the newly formed Drug Abuse Control Committee (DACC) (composed of members of the community).

The groups are:

DACC (3 people)
policemen (5 people)
interested parents (5 people)
school teachers (5 people)
Students, this group to be chaired by a minister (5 people)
(The number, of course, may vary.)

Each group will be given a proposal to present to DACC. (See appendix) They will meet for 10 minutes as small groups. During this time they must:

1. Elect a chairperson
2. Change the proposal if they wish to. Anything may be changed.
3. Prepare to present to DACC:
   - A. the plan, noting any changes
   - B. the cost
   - C. reasons to justify why it would be a good plan.

DACC is planning the meeting during this time. They also review all of the plans to be proposed, and prepare questions. (None of the citizens groups have any knowledge of the others' proposals. This forces them to think of positive reasons for their own plan, instead of negative reasons for the others.)

DACC then runs a 10 minute meeting of the full group., listening to each proposal, asking and allowing for questions.

Five minutes is then allowed for DACC to decide on a plan. This is an appropriate time to start processing behavior. The decision is announced, and a general discussion of why it was made lasts for about five minutes. (This period would be important to extend if that is possible.)

Suggested time allotment:

5 min. to review of causes of drug abuse.
5 min. to set the scene, explain game, divide into groups.
10 min. to sub-group meetings.
10 min. for general meeting.
5 min. for decision of DACC.
5 min. for general discussion and processing.

It is recommended that at least 2 adults be present to guide the children and answer questions.

APPENDIX

Role Plays for Elementary School Drug Committee Simulation

Recommendation of interested parents: an after-school activities program run by volunteers, with lots of crafts, hobbies, and field trips.
Cost: $8,000.00 for an administrator

Recommendation of policemen : an extra man on the police force, to work undercover, and turn in drug users. The law must be enforced.
Cost: $7,500 for a policeman

Recommendation of school teachers: a new drug education program in the schools. This includes new movies and materials, and hiring a new teacher half time to choose the materials, draw up a lesson plan, and supervise the program.
Cost: $1,000 for materials
$4,000 for a teacher

Students, chaired by a minister: a volunteer counseling program, young people and adults will volunteer to do counseling. The church will donate the space. Need to hire a half-time administrator.
Cost: $5,000 for administrator

DACC: Before the meeting, you must decide how long each group can speak, and how long to allow for questions. What are the things that you will want to know about each plan? Choose a timekeeper and a chairperson.

You will have 10 minutes for the meeting (not very long). You will have 5 minutes to make your decision, and 5 minutes to explain it and answer questions.

REMEMBER: The taxpayers will not want to spend much money. So you must decide how to get the most benefits for the least amount of money. GOOD LUCK!!!!!!!

JUNIOR HIGH LEVEL

SMOKING

PAMPHLETS:

There are a multitude of excellent pamphlets available free from:

American Cancer Society
25 Clinton Avenue
Cortland, NY 13045 756-2277

American Lung Association of Central NY
2013 E. Genesee Street
Syracuse, NY 13217
Enterprise 6069 (Request from Operator)

FILMS/FILMSTRIPS/VIDEOTAPES:

A BREATH OF AIR 832-361
21 min. J-S

Live-action, animation, microphotography, still photos and charts strive to teach a lesson by appealing to common sense. Covers the original 1964 Surgeon General's Report.

CIGARETTE SMOKING: TAKE IT OR LEAVE IT
14 min. IJS 392-18 BOCES

American Cancer Society filmstrip and record set investigates decision-making.

DECISION FOR MIKE 832-88
19 min. IJ

Addresses the circumstances that surround a young person's decision whether to smoke cigarettes. Utilizes a series of exaggerated humorous dialogues, rather than presenting facts in documentary fashion. American Cancer Society Film.

KIDS ON SMOKING 832-572
10 min. IJ

Persuasive film narrated by children, explores the full range of children's attitudes on smoking and clearly delivers the message: don't get hooked.

SMOKING: PAST AND PRESENT 832-366
15 min. IJ

Reviews the history of tobacco and its use by man, and traces evidence leading to present knowledge of health hazards related to use of tobacco. American Cancer Society Film.

TIME FOR DECISION 832-367
16 min. IJS BOCES

Tells the story of cigarette smoking in U.S. from World War I to the Surgeon General's Report.

TIME TO STOP IS NOW 831-394
4 min. JS

Presents evidence supporting the relationship between smoking and cancer. Stresses beneficial effects of stopping smoking as related to lung cancer, heart attacks. American Cancer Society Film.

TOBACCO PROBLEM: WHAT DO YOU THINK? (VO-00247)
17 min. C JS EBE BOCES

Points out dangers of smoking by presenting interviews and demonstrations by laboratory scientists and doctors. Emphasizes the reasons why people smoke, showing particularly how our culture influences smoking.

WHO'S IN CHARGE HERE? 832-361
14 min. JS

Backs up anti-smoking statements with scientific proof. Includes pre and post natal effects from smoking.

KIT:

SMOKING LUNG 123-35
HIRC (BOCES)

White plastic, sponges that resemble air sacs in the lungs discolor as they "smoke" a cigarette.

JUNIOR HIGH LEVEL

ALCOHOL

PAMPHLETS:

Alcohol & Drinking
The Facts Every Young Person Needs To Know

1980 Clarity Publications Inc.
P.O. Box 121
Shrewsburg, MA 01545

Drinking Etiquette For Those Who Drink
and Those Who Don't

Alcohol, Drug Abuse, & Mental Health Adm.
National Institute on Alcohol Abuse &
Alcoholism
5600 Fisher Lane
Rockville, MD 20857

Thinking About Drinking

Superintendent of Documents
U.S. Gov't Printing Office
Washington, DC 20402

Thirteen Steps to Alcoholism

National Council on Alcoholism
N.Y. Academy of Medicine Building
2 East 103rd Street
New York, NY

Student's Guide to Alcoholics Anonymous

Alcoholics Anonymous
World Services Inc.
P.O. Box 459
Grand Central Station
New York, NY 10017

What Everyone Should Know About Alcoholism

Channing L. Bete Co., Inc.
Greenfield, MA 01301

What Every Teenager Should Know About Alcohol

A Scriptographic booklet by:
Channing L. Bete Co.
South Deerfield, MA 01373

JUNIOR HIGH LEVEL

ALCOHOL

BOOKS:

Alcohol Education Curriculum Guide
For Grades 7-12

The University of the State of New York
The State Education Department
Bureau of Drug Education
1976 - Ed.

First Step
by Anne Snyder

Signet Book Cost $1.50
The New American Library, Inc.
P.O. Box 999
Bergerfiled, NY 07621

My Name Is Davy, I Am Alcoholic
by Anne Snyder

Signet Book Cost $1.25
The New American Library, Inc.
P.O. Box 999
Bergerfiled, NJ 07621

Sara T. Portrait of a Teenage Alcoholic
by Robin S. Wagner

Ballantine Books Cost $1.50

JUNIOR HIGH LEVEL

ALCOHOL

FILMS/VIDEOTAPE:

ALCOHOL AND YOU 833-55
28 min. JS BOCES

Documented treatment of drinking which explores the social pressures and the drinking habits that can lead an individual into becoming alcoholic.

ALCOHOL TRIGGER FILMS - AAA FOUNDATION FOR TRAFFIC SAFETY

These are short 2-3 min. films to be used with a discussion period afterward. Along with the films you will find a teacher's discussion guide on the trigger films, a teachers guide to alcohol countermeasures, and a student workbook. We encourage you to look over this program and use it in your classroom

The Party: Situation - A new boy in town wants to make friends with his peers and offers his house for a party while his parents are away.

The Mother: Situation - An intoxicated mother picks up her daughter at school and takes her and a friend to a shopping mall.

The Ride: Situation - Younger students are offered drinks by older friends and then invited to go for a ride.

CURIOUS HIBITS OF MAN 832-58
13 min. JS BOCES

Shows adults drinking too much at a cocktail party and an imaginative boy comparing their behavior to the animals he sees on a TV.

PINK ELEPHANT - Alcohol 832-532
15 min. JS

Solid factual information about causes and cure of alcoholism is presented against a background of fast paced action, light touches of humor.

THE ALCOHOL PROBLEM - WHAT DO YOU THINK? VO-00250
18 min. JS c EBE BOCES CCOC

In this video tape, drinking is examined three ways: Part I reveals social aspects, reviews history of alcohol usage, and economic importance of the alcohol industry. Part II analyzes the Chemistry of alcohol and physiological effects of drinking. Part III experiments with mice showing physical dependency and withdrawal symptoms caused by alcoholism.

THE DRINKING DRIVER 832-221
28 min. c JS

A series of drivers tests that present the audience with some solid evidence why the drinking driver should not get behind the wheel.

JUNIOR HIGH LEVEL

ALCOHOL

GAMES:

110-37 Innocent Until BOCES
J 3-9 60 min. period

This is a simulation game in which students role play the parts of individuals in the trial of a driver accused of negligent manslaughter, DWI, and killing a pedestrian. The driver's guilt is unclear. Discussion deals with personal & social responsibility.

110-36 "To Drink or Not To Drink" BOCES
J 5-16 players

The objective of this game is to involve students in personal decision making process applied to alcohol use. This game deals with the reasons for attitudes about and consequences of drinking.

JUNIOR HIGH LEVEL

DRUGS

PHAMPHLETS/BOOKLETS:

Drugs & You

A scriptographic Booklet

Channing L. Bete Co.
Greenfield, MA

Drugs - You? Survivors Handbook

Ed-U-Press 25¢ each
760 Ostrom Ave
Syracuse, NY 13210

For Kids Only: What You Should Know About Marijuana.

An easy to read booklet written for 12-15 year olds which details the psychological and physical effects of "pot" scientific facts are related in an easily understandable format and simple clear illustrations help to promote interest and retention.

Send to Modern Talking Pictures Services
5000 Park Street North
St. Petersburg, FL 33704

BOOK:

"Marijuana: Time for a Closer Look"

Deals about the health hazards of marijuana, different aspects of marijuana use and impact.

by Curtis L. Janeczk
forward Dr. Robert DePont

VIDEOTAPE:

The Drug Problem: What do you Think? VO-00249
17 min. JSA C EBE CCOC

Takes a wide range look at drugs, from the contents of household medicine cabinets to street drugs.

Demonstrates effects of drug abuse in a series of laboratory experiments and a documentary on a drug overdose case.

JUNIOR HIGH LEVEL

DRUGS

FILMS:

JOURNEY IN TIME 833-85
26 min. JS BOCES

Hard-hitting film is an actual documentary on drug abuse 1960-1970.

THE PERFECT DRUG FILM 833-86
31 min. J-S BOCES

Provocative film takes a searching historical look at mankind's age old quest for new ways to "turn on and tune out". Proves that the perfect drug is what we need least of all.

UP PILL, DOWN PILL 833-70
24 min. J-S BOCES

Explores different life styles through which the central figures try to adjust to disappointments and frustrations.

KIT:

DRUG DECISION 123-43
J BOCES

A programmed study course to be used in conjunction with Drug Attack (110-30) Teacher and student manuals and workbooks.

SENIOR HIGH LEVEL

SMOKING

PAMPHLETS:

There are a multitude of excellent phamphlets available free from:

American Cancer Society
25 Clinton Avenue
Cortland, NY 13045
756-2277

American Lung Association of Central NY
2013 E. Genesee Street
Syracuse, NY
Ask operator for Enterprise 9069

Smoker's Self-Testing Kit

U. S. Department of Health and
Human Services
Public Health Service
Center for Disease Control
Bureau of Health Education
National Clearinghouse for Smoking
and Health
Atlanta, Georgia 30333

HEW Publication NO. (CDC) 75-8716

FILM/VIDEOTAPE:

LET'S CALL IT QUITS 833-164
28 min. BOCES

Tom Bosley and Marion Ross from TV's "Happy Days" struggle through Tom's attempts and final success at stopping smoking.

THE FEMININE MISTAKE VO-PYR
20 min S BOCES

A videotape which covers the physiological problems associated with females' smoking. Very vividly drives home an impression.

KIT:

Smoking Lung (HIRC) BOCES 123-35

White plastic sponges that resemble air sacs in the lung discolor as they "smoke" a cigarette.

SENIOR HIGH LEVEL

ALCOHOL

PAMPHLETS:

Alcohol - Some Questions & Answers

National Institute on Alcohol
Abuse & Alcoholism
5600 Fishers Lane
Rockville, MD 20857

(DHEW - Pub. No. (HSM) 71-9048

Alcoholism

Blue/Cross & Blue/Shield Assoc.
840 North Lake Shore Drive
Chicago, IL 60611

Alcoholism: A Merry-go-round
Named Denial (Joseph L. Kellermann)

Hazelden Ed. Services
Box 176
Center City, MN 55012

Alcoholism & The Family 1978
by Donald E. Meeks, D.S.W.

Alcoholism & Drug
Addiction Research Foundation
Toronto, Canada

Drinking Etiquette - For Those Who Drink
and Those Who Don't

Alcohol, Drug Abuse & Mental Health Adm.
National Institute on Alcohol Abuse & Alcoholism
5600 Fishers Lane
Rockville, MD 20857

Students Guide to Alcoholics Anonymous

Alcoholics Anonymous
World Services Inc.
P.O. Box 459, Grand Central Station
New York, NY 10017

The Illness called Alcoholism 1973

American Medical Assoc.
535 North Dearborn Street
Chicago, IL 60610

Thirteen Steps to Alcoholism

National Council on Alcoholism
New York Academy of Medicine Bldg.
2 East 103rd Street
New York, NY

What Everyone Should Know About Alcoholism

Channing L. Bete Co. Inc.
Greenfield, MA 01301

BOOKS:

Alcohol Education - Curriculum Guide
for Grades 7-12

The University of the State of NY
The State Education Dept.
Bureau of Drug Education

"I'll Quit Tomorrow"
by Vernon Johnson

Hazelden Ed. Services
Box 176
Center City, MN 55012
$10.95 (182 pages)

"High On Life"
by Lee Silverstein

Health Communications Inc.
2119-A Hollywood Blvd.
Hollywood, FL 33020
(story on addiction and recovery)

FILMS:

ALCOHOL ABUSE: THE EARLY WARNING SIGN
21 1/2 min. c Sale $325 Rent $30 (1977)

Available from: AIMS Instructional Media Inc.
626 Justine Ave.
Glendale, CA 91201

FILMS:

In this film hosted by Henry Fonda, ten signs that may indicate a developing alcohol dependency are dramatized. Separate vignettes illustrate each sign, including increased tolerance and consumption, wanting to get high quickly, irritability when questioned about drinking, and deteriorating job performance.

ALCOHOL AND YOU 833-55
28 min. JS

Documented treatment of drinking which explores the social pressures and the drinking habits that can lead an individual into becoming an alcoholic.

ALCOHOLIC WITHIN US 833-109
25 min. S

An allegory in which six actors represent emotions: fear, loneliness, inadequacy, insecurity, guilt and resentment. Their dialogue reveals the progressive steps in their growing dependency on the drinking habit, its reinforcement of the already destructive tendencies within the personality.

ALCOHOLISM - A MODEL OF DRUG DEPENDENCE 832-281
20 min. S BOCES

Examines the problem of alcoholism in our society. A computer, which is programed to play a series of video tapes dealing with the problem, serves as the film's medium of presentation.

MY NAME IS DAVID...AND I'M AN ALCOHOLIC
23 1/2 min. c Sale $340 Rent $30

A film featuring David, a middle aged man who enters his company's occupational alcoholism program. The program traces his step by step progress through counseling and inpatient care in a rehabilitation center. When David returns to job and family the understanding of all concerned and the support of his AA sponsor are keys to his continuing success in regaining control of his life.

NEW BEGINNINGS: WOMEN, ALCOHOL AND RECOVERY
23 min C Sale $340 Rent $40 (1977)

Available from: AIMS Instructional Media Inc.
626 Justine Ave.
Glendale, CA 91201

Designed to change attitudes and break stereotypes. This film follows the recovery of three women in home, recreational, and work settings. Featured are a young woman recovering from alcohol and drug abuse; a black women; and a career woman and grandmother who found new meaning in her life through recovery from alcoholism.

TEENANGE DRINKING: HOW ABOUT ANOTHER ONE!
15 min. S 832-424

Why do people start drinking? Is alcohol a drug? Does alcohol make you feel better, or is it a crutch? These questions and others will help generate serious answers.

THE ALCOHOLISM FILM 832-372
23 min. S

A documentary look at factors which characterize the alcoholic in today's society. Alcoholism is presented within the spectrum of diseases which can be diagnosed and treated.

THE DAY I DIE 832-604
14 min, S

The reality of what can happen under the influence of alcohol is dramatically brought home in this film of a 17 year old boy killed in an auto accident. Narrated by the dead boy.

THE DWI DECISION
25 min. color/sound $380 16mm

(For anyone who may make drinking-driving decision)

Visucom Productions Inc.
P.O. Box 3563
Stanford, CA 94304

THE FETAL ALCOHOL SYNDROME 832-551
13 min. S

Dramatically shows human and animal offspring and what can happen to them when their mothers drink.

UNTIL I GET CAUGHT 833-221
27 min. JS

Documentary on the dangers, injuries and deaths involved in drinking and driving in America. Emphasizes the need to view the tragedies of drunken driving as if they involved each of us personally.

SENIOR HIGH LEVEL

DRUGS

PAMPHLETS:

Drug Abuse Prevention (For You and Your Friends)
DHEW Publication No. (ADM) 79-583

National Institute of Drug Abuse
5600 Fisher Lane
Rockville, MD 20857

Drugs You? Survivors Handbook 25¢ each

Ed-U-Press
760 Ostrom Ave.
Syracuse, NY 13210

Health Consequences of Marijuana Use
(Jan. 16-17, 1980)

Office of Senator Mathias
Russell Senate Office Building
Washington, D.C. 20510
Attention: Jacqueline Besher

Heroin - (A scriptographic Fact Folder)

Channing L. Bete Co. Inc.
Greenfiled, MA

How Was the Trip - A play - concerned with drug abuse.

National Institute of Mental Health
5600 Fishers Lane
Rockville, MD 20852

BOOKS:

Adolescent Workshop Books

1. Do My Parents Understand Me
2. But They're My Firends
3. Why Can't I Do It My Way
4. Do My Parents Love Me
5. Can Tests Help Our Children Learn
6. The Sexual Adolescent

From: Fred Streit-Ed.D.
168 Woodbridge Ave.
Highland Park, NJ 08904
(201-572-3120)

Parents, Peers & Pot

Prevention Branch
Division of Resource Development
National Institute on Drug Abuse
5600 Fishers Lane
Rockville, MD 20857

FILMS/VIDEOTAPES:

A WALK IN THE PARK
20 min. C Rental or Purchase Fee

King Screen Production
320 Aurora Ave. N.
Seattle, WA 98109

A Walk in the Park is about the causes of drug abuse - aimlessness, alienation and the lack of a center to life. Drugs in this view are not so much a problem as an attempt at a solution to a problem.

DEPENDENCE A NEW DEFINITION 833-292
20 min. S

Points out that dependence can be a positive factor. Theories of causation of dependency are covered. Raises questions about the inability of the family and society to fulfill the individual's dependency needs.

DRUG ABUSE SELF-AWARENESS FOR HIGH SCOOOL STUDENTS
17-21 min. C BOCES

The three videotape modules in the self-awareness series on Drug Abuse are designed to help students to deal more maturely with this issue. The programs present no cognitive material, overt or concealed judgment or dogma. Their goal is to stimulate a series of discussions helping students to become more aware of their own feelings and attitudes. True self-awareness leads to more responsible decisions and behavior with respect to drugs. Fear, humiliation and anger, and compassion are the three programs.

READING, WRITING AND REEFER
52 min. BOCES

A documentary hosted by NBC's Edwin Newman touches controversial bases on the marijuana issue. Videotape.

SOCIAL RESPONSIBILITY: IT'S MY HOBBY
10 min. S 832-298

Ed discovers that his friend, Scott, is selling drugs and that his customers include younger children. What should Ed do? Students are encouraged to examine their own sense of social responsibility, particularly in the face of peer pressure.

THE PERFECT DRUG FILM 833-86
31 min. JS

Provocative film takes a searching historical look at mankind's age old quest for new ways to "turn on and tune out" proves that the "perfect drug" is what we need least of all.

GAMES:

DRUG DEBATE - 110-14 S BOCES

Community at the Crossroads: A drug education simulation game - 110-31.

INNOCENT UNTIL - 110-37 S
(50 min period) 3-9 players

This is a simulation game in which students role-play the parts of individuals in the trial of a driver accused of negligent manslaughter...DWI and killing a pedestrian. The driver's guilt is unclear. Discussion deals with personal and social responsibility.

TO DRINK OR NOT TO DRINK - 110-36 S
5-16 players

The objective of this game is to involve students in personal decision making processed applied to alcohol use. This game deals with the reasons for, attitudes about and consequences of drinking.

KIT

If Drugs are the Answer 392-5
15 min.

Filmstrip kit with a series of six programs concerning these major areas: family, friends and group acceptance, sexuality, work and careers, society, personal growth.

MISCELLANEOUS

SPIRIT MASTERS   Values   Educational Insights
20435 South Tillman Avenue
Carson, California 90746

"The approach taken here is a simulation of situations through cartoon settings. The student experiences looking at what he or she values. The emphasis is on thinking through and seeing valuing as a personal process.

AWARENESS GAMES

A book of games stressing personal growth through group interaction. St. Martin's Press, 175 Fifth Avenue, New York, NY 10010

CASSETTE TAPES

Effective Communication by Jeffrey Schrank, Argus Communications - Niles, Ill.

STORIES

The Interstate Printers and Publishers, Inc., Danville, Ill. 61832
Teaching Moral Values Through Behavior Modification (Intermediate Level)

Series of stories to help students understand the meaning of moral values through an "open ended" approach to learning. Uses small group discussions.

CAN OF SQUIRMS

Grades 5, 6, & 7. Has a series of open ended role-playing situations in which students act out different parts.

GAMES

Roll a Role, The Ungame Company, Anaheim, California 92806

An action game in which players have three minutes to explore a subject or situation as seen through someone else's eyes.

FILMSTRIPS

How Do You Feel   Salenger Educational Media, 1635 12th Street, Santa Monica, California 90404

Set 1 K-3   Moving Away, Wanting to Play, The Bike
Set 2 K-3   The Jackpot, The Pet, The Errand

Has filmstrips plus cards with incomplete sentences on them such as: When I break a toy... When I feel loved I also feel...

Vandalism, Stealing, Lying, and Hurting People (Grades 4-5), Learning Tree Filmstrips, Opportunities for Learning, Inc., 8950 Lurline Ave., Dept. PT 410, Chatsworth, California 91311 $72.00

Discovering Your Personality, Guidance Associates, Harcourt Brace Jovanovich, (Belonging to a Group).
Exploring Your Feelings   Who Are You

534

FILMSTRIPS-CONTINUED

First Things   *Primary/Elementary Sound Filmstrips*

But It Isn't Yours   You Promised   The Trouble With Truth

What Do You Do About Rules

Self Expression & Conduct

Folk Tales and Fairness   Dreams and an Old Trombone

Program B

Rope, Wood, and Clay   What We Care About

Values in Action, *Winston Press, Inc., 25 Groveland Terrace, Minneapolis, Minn. 55403.*

Role Playing Situations for the Intermediate Grades Holt, Rinehart, and Winston Some filmstrips in this series are: My Best Friend, It's All Your Fault, He Hit Me First, The Trouble with Nikki, Benefit of the Doubt, Sticky Fingers.

How Do You Feel Funny Face? *EAV Sound Filmstrips, Pleasantville, NY 10570*
Pt. 1 A Feeling Has a Very Special Feeling
Pt. 2 Room For Many Feelings
Pt. 3 Talking With My Whole Self
Pt. 4 Changing Feelings/Changing Me

Listening Looking Feeling

BFA Educational Media, A division of Columbia Broadcasting

Open Ended Stories, *Imperiale Film Co., Lakeland, Fla. 33803 (Grade level-primary and intermediate).*

Open Ended Stories is used to involve children in examining and strengthening positive values. The values involved are integrity, responsibility, courage, friendship, and respect for the property of others.

Green Circle Filmstrips, *Carrie Sounds, North Wales, PA*

BIBLIOGRAPHY

Adler, Ron & Towne, Neil	Looking Out/Lookint In (Holt, Rinehart, Winston NY)	
Allport, Gordon	Prejudice	
Blakeslee, Thomas R.	The Right Brain Anchor Press/Doubleday, Garden City NY	
Brandon, Nathaniel	The Disowned Self, The Psychology of Self Esteem Nash Pub. Corp., 9255 Sunset Blvd. Los Angeles, California 90069	
Buscaglia, Leo	Love	Fawcett Crest, NY
Buzan, Tony	Use Both Sides of Your Brain	E.P. Dutton, NY
Cudney, Milton	Self-Defeating Behaviors	
" "	Self-Defeating Behavior Characters	
" "	Implementation and Innovation (Life-Giving Enterprises, Inc., Kalamazoo, Michigan 49007).	

BIBLIOGRAPHY-CONTINUED

Erikson, Erik	Childhood and Society	W.W. Norton & Co., NY
Freed, Alvyn	T.A. For Tots T.A. For Teens	Jalmar Press, Sacramento
Gibran, Kahlil	The Prophet	Alfred A. Knopf Pub.
Glasser, William	Reality Therapy	Harper & Row, NY
Harris, Thomas	I'm OK, You're OK	Avon Books (959 8th Avenue, NY, NY 10019)
Harrison, Phyllis	Getting It Together	Globe Book Co, NY
Hoeper, Kutzleb, Stobbe, Weber	Awareness Games	St. Martin's Press, 175 5th Ave., NY 1001
Howe, Leland & Howe, Mary	Personalizing Values	Hart Pub., Inc. NY
James & Longeward	Born to Win	Signet Books (New American Library, 1301 Ave. of the Americas, NY, NY 10019).
Kubler-Ross, Elizabeth	On Death and Dying	MacMillan Pub. Co, NY
Mayeroff, Milton	On Caring	Perennial Library (Harper & Row)
Haynes, Marya	Last Rights A Signet Book	A New American Library
Palomares, Ulvaldo & Ball, Geraldine	An Overview of the Human Development Program	
Powell, John	Why Am I Afraid To Tell You Who I Am?	Argus Comm, Niles, Ill. 60648
Reichart, Richard	Self-Awareness Though Group Dynamics	(Cebco Standard Pub., 9 Kulick Rd., Fairfield, NJ 07006
Restar, Richard	The Brain	Warner Books, 75 Rockefeller Plaza, NY., NY 10019
Reuben, Brent & Budd, Richard	Human Communication Handbook Simulations & Games	
Silverstein, Lee	Consider the Alternatives	(Comp Care Pub., 2415 Annapolis Lane, Suite 140, Minneapolis, Minnesota 55441)
Simon, Sidney	I Am Loveable and Capable	(Argus Communications, Niles, Ill. 60648)
Simon, Sidney	Negative Criticism	(Argus Communications, Niles, Ill. 60648)
Simon, Sidney & Clark, Jay	Beginning Values Clarification: Strategies for the Classroom	(Penant Press, 8265 Commercial St., No. 14, La Mesa, Calif. 92041)
Steiner, Claude	Scripts	Bantam Books, NY
Viscott, David	Risking	Pocket Books, NY
Yamamoto, Kaoru	The Child and His Image	Houghton Mifflin Co.

RESOURCES FOR
TEACHERS & ADMINISTRATORS

Smoking - Pamphlets

Call It Quits - (the latest advice on how
to give up cigarettes)

Office of Cancer Commission
National Cancer Institute
Bethesda, MD 20205

Clearing the Air: A Guide to Quitting Smoking

Office of Cancer Communications
National Cancer Institute
Bethedsa, MD 20205
(N.H. Pub. No. 80-1647)

Guidelines for Development of School
Policies Regarding Smoking

The University of The State Of NY
The State Education Department
Bureau of Drug Education
Albany, NY 12234

How To Stop Smoking
(An experienced doctor guides you in
a smoking withdrawal program)

American Heart Association
Upstate New York Chapter Inc.
1212 James Street
Syracuse, NY 13203

If You Must Smoke

D.H.E.W. Pub. No. (CDC) 75-8706
U.S. Department of H.E.W.

Public Health Service
Center For Disease Control
National Clearinghouse for Smoking
and Health
Bethesda, MD 20016

Personal Guide For The Smoking Scene

Spenco Medical Corp.
P.O. Box 8113
Waco, Texas 76710
$6.00/100

"Smoking and Your Health"
W.R. Spence M.D.

Spenco Medical Corp.
P.O. Box 8113
Waco, Texas 76710

"Smoking Do You"
Smokers Self-Testing Kit

Department of Health
State of New York
Robert D. Whalen, M.D., Commissioner
Albany, NY

"Smoking: Facts You Should Know"

A.M.A.
535 North Dearborn Street
Chicago, IL 60610

"Your Heart - What Smoking May Do"
Supplement to Listen Vol. 24, No. 2

Narcotics Ed. Inc.
P.O. Box 4390
Washington, D.C. 20012
10¢ per copy

Smoking - Books

Basic Concepts of Tobacco & Smoking
Available from (HIRC) BOCES

11-12-13 - World Conference on Smoking and Health

A Summary of the Proceedings

American Cancer Society
New York Division
Cortland County Unit
25 Clinton Avenue
Cortland, NY 13045

Smoking Programs for Youth

U.S. Dept. of Health & Human Services
Public Health Service
National Institute of Health
Bethesda, Maryland 20205
NIH Publication No. 80-2156 June 1980

Smoking - Posters

Listen Smokers

You don't have to wait 20 years for cigarettes to affect you. It only takes 3 seconds.

U.S. Dept. of Health and Human Services
Public Health Service
Center of Disease Control
Pub. No. (COC) 74-8730

Other posters available from your local American Cancer Society and American Lung Association

A POSITION STATEMENT

AMERICAN ASSOCIATION FOR HEALTH, PHYSICAL EDUCATION, AND RECREATION

a Department of the National Education Association

Distributed by
[illegible]
Syracuse, New York
Phone: (315) 473-4623

SMOKING: THE SCHOOL'S RESPONSIBILITY

The report of the Surgeon General's Committee, *Smoking and Health*, published in January 1964, is clear and unequivocal in its indictment of cigarette smoking as a health hazard. The schools must, therefore, accept their responsibilities for providing programs consistent with the known facts. The actions of the schools should be directed toward several different areas of the total school program, and consideration should be given to each of the following: (1) the importance of adult behavior as an example to youth; (2) the timeliness and nature of the instructional program; (3) the utilization of the motivational potential inherent in sports participation; and (4) the elimination of the practice of providing school smoking facilities.

The fact that most of those who smoke regularly start during the school years points up the role the schools must play. The development and continuation of the smoking habit by children and youth is related to emulation of what appears to be accepted adult behavior. Efforts to educate in home and school begin with the example. School personnel, particularly teachers and coaches, frequently serve as models which will be imitated by many children. Thus the school's fundamental responsibility in providing an effective smoking education program involves behavior by teachers which will reinforce the more formal learning experiences. The American Association for Health, Physical Education and Recreation urges all school personnel who smoke to recognize the inevitability of education by example, and to take appropriate action to provide an image consistent with the facts regarding smoking and health.

If present and future generations are to be educated concerning the effects of smoking on health, an effective educational program must anticipate the problem and thus begin prior to the teen years. The AAHPER urges a program of instruction throughout the primary grades emphasizing experiences which will provide children with an opportunity to develop the foundations essential to self-understanding and self-acceptance. Such a program should be carried out with an awareness and understanding of the child's developing and emerging system of values which will ultimately serve as a sounding board for weighing facts and making choices. The effectiveness of later educational efforts related to smoking will in large measure depend upon the nature as well as the quality of the primary school program.

In the intermediate grades a clearly identified segment of the school day should be devoted to a health instruction program in which the effective physical, social, and mental functioning of the human organism provides the content. Boys and girls should be given opportunities to study many topics with which they will be concerned, including smoking. The making and testing of decisions and the evaluation of alternatives should have prominent places in the intermediate grade school program.

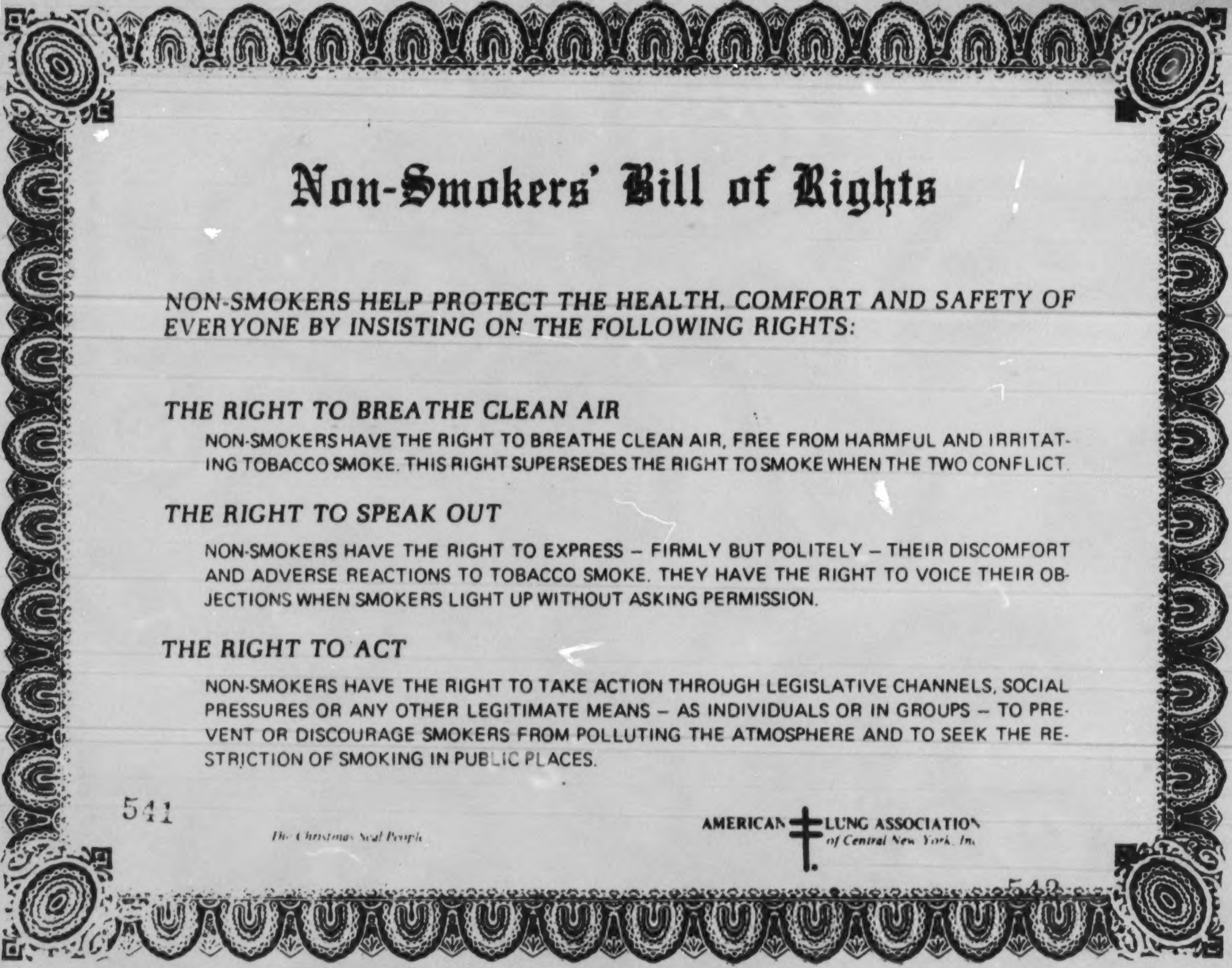
The health instruction of the junior and senior high school student should provide an opportunity to explore in depth the psychological, physiological, and sociological factors to be considered in making a decision regarding smoking. Evaluation of pressures such as those present in advertising should be a part of such experiences, and the importance of basing decisions on facts should be emphasized.

Additional learning experiences should be planned and provided through correlated or integrated materials in other courses, to reinforce and expand understandings. Responsibility for the coordination of the school's efforts should be assigned to the individual responsible for the school health program.

For all age levels, it would be wise for schools to recognize that evidence continues to mount supporting the position of coaches and trainers that athletes should not smoke. The acute impairment of cardio-pulmonary efficiency resulting from smoking is not compatible with the striving for maximal performance inherent in competitive athletics. The Association urges those responsible for sports programs to utilize the motivational potential of sports participation in educating youth to refrain from smoking during the years when the decision to smoke or not to smoke is most likely to be made.

Many schools have provided smoking rooms for students and staff. However, the provision of such rooms must be justified on the broad base of effect on the total educational effort of the school. As a societal institution the school has an obligation to children to provide experiences which contribute to their effective function as citizens and health is one of the most important factors in enabling the individual to assume the reponsibilities of citizenship. Certainly no child should be exposed to practices in the school which are likely to influence his behavior in an undesirable way. Often cited as the reason for having smoking facilities in the school is that with such a room available the educational program is less likely to be disrupted by enforcement of no-smoking regulations which may occupy disproportionate time and effort of administration and faculty. A short-range disciplinary problem should not, however, prevent consideration of a long-range health objective. The Association recommends that all schools presently providing facilities for smoking re-examine this practice and take appropriate steps to eliminate such facilities.

A mandate for action is thus provided for those professionally concerned with the health and education of children and youth. Further research is necessary to make possible the elimination or control of the harmful substances present in tobacco smoke and to aid in the development of the most effective and appropriate educational programs for youth. The AAHPER commends those persons and organizations engaged in or supporting such research, and recommends that such research efforts be intensified. ■



Non-Smokers' Bill of Rights

NON-SMOKERS HELP PROTECT THE HEALTH, COMFORT AND SAFETY OF EVERYONE BY INSISTING ON THE FOLLOWING RIGHTS:

THE RIGHT TO BREATHE CLEAN AIR

NON-SMOKERS HAVE THE RIGHT TO BREATHE CLEAN AIR, FREE FROM HARMFUL AND IRRITATING TOBACCO SMOKE. THIS RIGHT SUPERSEDES THE RIGHT TO SMOKE WHEN THE TWO CONFLICT.

THE RIGHT TO SPEAK OUT

NON-SMOKERS HAVE THE RIGHT TO EXPRESS – FIRMLY BUT POLITELY – THEIR DISCOMFORT AND ADVERSE REACTIONS TO TOBACCO SMOKE. THEY HAVE THE RIGHT TO VOICE THEIR OBJECTIONS WHEN SMOKERS LIGHT UP WITHOUT ASKING PERMISSION.

THE RIGHT TO ACT

NON-SMOKERS HAVE THE RIGHT TO TAKE ACTION THROUGH LEGISLATIVE CHANNELS, SOCIAL PRESSURES OR ANY OTHER LEGITIMATE MEANS – AS INDIVIDUALS OR IN GROUPS – TO PREVENT OR DISCOURAGE SMOKERS FROM POLLUTING THE ATMOSPHERE AND TO SEEK THE RESTRICTION OF SMOKING IN PUBLIC PLACES.

541

The Christmas Seal People

AMERICAN LUNG ASSOCIATION
of Central New York, Inc.

ALCOHOL - PAMPHLETS, REPORTS AND STUDIES

A History of Our Confused Attitudes Towards Beverage Alcohol
by Daniel J. Anderson

Hazelden Educational Services
Box 176
Center City, MN 55012

Alcohol & Drug Studies
by Charles C. Thomas

Publisher
2600 South First Street
Springfield, IL 62717

Early Recognition of Alcoholism and Other Drug Dependence
by Richard O. Heilman M.S.

Hazelden Ed. Services
Box 176
Center City, MN 55012
Cost 50¢

Here's Looking At You - The Drinking American
DHEW Pub. No. (ADM) 76-348

National Institute of Alcohol
Abuse and Alcoholism
5600 Fishers Lane
Rockville, MD 20852

The Addiction Experience
by Stanton Reele

Hazelden Ed. Services
Box 176
Center City, MN 55012

The New Alcoholics: Teenagers
by Jules Saltsman
Public Affairs Pamphlets No. 499

Public Affairs Pamphlets
381 Park Ave South
New York, NY 10010
Cost 50¢

ALCOHOL - BOOKS

Alcohol & Your Health
(HIRC) BOCES

Alcoholism - A Family Illness
by Betty Reddy

Lutheran Center for Substance Abuse
Lutheran Alcoholism Treatment
1700 Luther Lane
Park Ridge, IL 60068

Alcohol - It's Use, Abuse and Therapy
Expert practical advice with Christian insights.
by Gerald Schomp

Our Sunday Visitor Inc.
Noll Plaza
Hutington, IN 46750
Cost $7.95

Basic Concepts of Alcohol
(HIRC) BOCES

Consider The Alternatives
by Lee Silverstein

Comp. Care Publications
2415 Annapolis Lane, Suite 140
Minniapolis, MN

$5.95 (for all of us - a guidebook and a personal testament of living and solving life problems - A beautiful blend of text with practical exercises)

Facts & Fantasies About Alcohol
(HIRC) BOCES

High On Life
by Lee Silverstein

Health Communications Inc.
2119-A Hollywood Blvd.
Hollywood, FL 33020

(Story on alcohol addiction and recovery)

I'll Quit Tomorrow
by Vernon Johnson

Hazelden Educational Services
Box 176
Center City, MN 55012

Learning About Alcohol - A Resource Book for Teachers
by Samuel A. Miles - Editor

American Association of Health
Physical Education and Recreation
Publication Sales
1201 16th St. N.W.
Washington, D.C. 20036

Teaching About Alcohol
(concepts, methods and classroom activities)

Allyn & Bacon Inc.
470 Atlantic Ave
Boston, MA 02210

You & Your Alcoholic Parents
(HIRC) BOCES

The following publications are available from Hazelden:

ALCOHOLISM: A Treatable Disease

A straight forward look at what to expect from alcoholism with a convincing message of hope: alcoholism is indeed a "treatable disease."

Hazelden Educational Services
Box 176
Center City, MN 55012

BLACKOUTS

This pamphlet describes the ominous and frightening experience the alcoholic is victimized by.
5 pages Cost 35¢

Hazelden Educational Services
Box 176
Center City, MN 55012

CHEMICAL DEPENDENCY & RECOVERY ARE A FAMILY AFFAIR

A new booklet from the Johnson Institute describing the family illness and the process and rewards of family intervention.
38 pages Cost $1.95

Hazelden Educational Services
Box 176
Center City, MN 55012

DETACHMENT

Some answers to hard questions for those who share their lives with an alcoholic. A good booklet for anyone trying "to let go".

Hazelden Educational Services
Box 176
Center City, MN 55012

DYNAMICS OF ADDICTION

A look at addiction, how it develops, and how it continues.

Hazelden Educational Services
Box 176
Center City, MN 55012

MEDICAL ASPECTS OF INTOXICATION

Dr. George Mann, Medical Director, St. Mary's Treatment Unit, provides the reader with a physician's viewpoint on the progressive and destructive course of the illness.
4 pages Cost 50¢

Hazelden Educational Services
Box 176
Center City, MN 55012

RECOGNITION AND INTERVENTION

The supervisor's and manager's roles and responsibilities in recognizing chemical dependency in employees are examined.
9 pages Cost 50¢

Hazelden Educational Services
Box 176
Center City, MN 55012

RECOVERY OF CHEMICALLY DEPENDENT FAMILIES

A description of the effect of alcoholism on family members and the recovery process for the whole family.
9 pages Cost 50¢

Hazelden Educational Services
Box 176
Center City, MN 55012

THE SUPERVISOR: PART OF THE HELPING NETWORK

A three-ring vinyl manual for managers and supervisors that supplies information about chemical dependency. It contains information for assessing employee performance and suggestions for referral into a helping process.
Single Copy Price Cost $4.95
50 or more copies $4.50

Hazelden Educational Services
Box 176
Center City, MN 55012

TODAY IS DIFFERENT

This booklet helps in identifying both chemical dependency as well as misuse for anyone concerned about children and young adults. It outlines an effective process of help.

13 pages	Cost $1.00

Hazelden Educational Services
Box 176
Center City, MN   55012

WHY HAVEN'T I BEEN ABLE TO HELP?

This pamphlet lists some common attitudes and behaviors of concerned persons that can be changed.

6 pages	Cost 35¢

Hazelden Educational Services
Box 176
Center City, MN   55012

WHY MUST THEY SUFFER SO LONG?

Alcoholism does not have to be endured. Ignorance of what can be done keeps many families sick.

4 pages	Cost 35¢

Hazelden Educational Services
Box 176
Center City, MN   55012

STATE OF NEW YORK

COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION AND EDUCATION

Office of Alcoholism and Substance Abuse
EXECUTIVE PARK SOUTH
ALBANY, NEW YORK 12203

SOME FACTS ABOUT THE COMMISSION AND ITS SERVICES

Legal Mandate

The commission was created by the State Legislature on April 1, 1978, through a reorganization of the State laws governing the Department of Mental Hygiene. It is the department within the Office of Alcoholism and Substance Abuse which is primarily responsible for Prevention and Education efforts dealing with alcohol and drug abuse. The two other OASA departments—the Division of Alcoholism and Alcohol Abuse, and the Division of Substance Abuse Services, are responsible for other areas wich primarily include treatment and rehabilitation.

To summarize, some of the specific mandates include:

—Development and implementation of education programs on alcohol and substance abuse and their effects, either singly or in combination with each other.

—Prevention programs with particular emphasis on children and youth.

—Administration of school-based substance abuse prevention and education programs.

—Promotion of various related Statewide programs or activities, in conjunction with efforts of governmental agencies on federal, state, regional or local levels, as well as efforts of non-governmental organizations.

—Stimulate public interest and support for such education and prevention activities.

—Provide information on facilities available within the State on all programs for alcoholism and drug abuse treatment, education and prevention, and act as a clearinghouse for public information on such facilities.

Services Provided

To carry out these legal directives, the Commission provides a combination of exclusive services and joint efforts in liaison with the other members of OASA, as well as other State entities which include the Education Department, the Department of Mental Hygiene, the Division for Youth, and many local or non-governmental organizations. Services for teachers, agencies and other professionals are regularly announced in the Commission's newsletter "Prevention Pursuits," and include training, technical assistance, resource identification, public service informational campaigns via broadcast and print media, and funding and administration of many school-based programs.

Information Services for the Public

Information on alcohol and drug abuse of all types may be obtained by writing or calling CASAPE, Box 8200, Albany NY 12203, phone (518) 457-7425.

The Resource Center of the Commission regularly handles a large volume of mail for information on:

—Alcohol and substance abuse prevention efforts.

—Information on the effects of alcohol, as a drug, in relation to safety and driving, its effects on pregnancy and its effects on mental as well as physical health.

—Information on licit and illict drugs, medications and tobacco included, covering all of the above areas.

Principal users of the Resource Center are:

—Students with actual or potential drug problems, or who are doing school reports.

—Teachers and administrators.

—Parents and other adults.

—Other agencies which are involved with alcohol and substance abuse prevention and education.

—Legislators, in response to requests from constituents.

—Libraries.

—A wide variety of members of the general public who have general or specific requests about use, abuse or prevention.

—Physicians and other professionals.

Sources of materials supplied include:

—Commission publications, original to the agency.

--Federal publications from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism (some of which are reprinted in quantity by the Commission).

—A wide variety of other items, primarily purchased from other agencies, organizations or commerical publishers.

—Various filmmakers.

At this time, the Commission makes available approximately 90 publications and a dozen different films to those requesting information. Included are materials specializing in the particular problems or perspectives of women, minorities, very young children, senior citizens, and the Spanish speaking.

JACKSON JUNIOR HIGH

A Series of Four Films
and Related Curriculum Materials
for Grades 5 through 8
on the Responsible Use or Non-use
of Alcohol

From the Office of Education and the
National Institute of
Alcohol Abuse and Alcoholism,
U. S. Department of Health, Education
and Welfare

WINE
BEER
WHEAT

350- 550

Alcohol can be good or bad.

But should you teach about it in school?

Alcoholism is America's third most serious health problem. It's the nation's number one drug, for all ages. Narcotics and marijuana get much more attention in the press and in the classroom, but there are more than 9 million problem drinkers in the United States. Beyond the loss in productivity and social well-being, there is an astonishing cost in human life. Nearly 15,000 traffic fatalities each year involve problem drinkers. That's 40 deaths every day.

A majority of Americans drink, most of them responsibly. Alcoholic beverages are enormously popular as part of American social activities. They help people relax, heighten pleasure, and enhance the enjoyment of food. But some of America's 80 million social drinkers have their problems as well. Over 7,000 people are killed on the highways every year by "legally sober" social drinkers who are driving with dulled reflexes. And sometimes both drinking and abstention can create friction even among friends. When a social drinker simply doesn't feel like having a drink, well-meaning hosts and friends often exert pressure — "Have just a little one." The person who chooses to abstain for life often seems to provoke both uneasiness and ridicule from non-abstainers.

For the problem drinker, the pleasure of alcohol has become a burden, though it may not be recognized as such. But there's seldom only one victim. It is estimated that the typical problem drinker on the average seriously affects the lives of four other people. A very great many of these are children. Some of them may be your students.

Why is alcohol an important topic for adolescents?

Every young American grows up in a society where drinking is typical youthful behavior. About two-thirds of U.S. seventh graders have already had at least one drink. A quarter of the youngsters in this age group report being drunk at least once *this year*. Adolescent drinking, and problem drinking, occur in every ethnic group and at every social level.

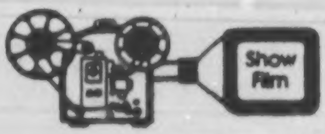
On the other hand, a young person's alcohol problem may have nothing to do with whether he or she drinks. Difficulties in relating to a parent, a sibling, or a friend who is abusing alcohol can create tremendous pressure, confronting a youngster with some very difficult decisions. Is there something the youngster could do to help? Should the young person seek the help of professional counselors?

These young people are facing decisions that deserve careful consideration. Should they drink at all? If they do drink, what limits should they set upon themselves? If their parents forbid alcohol, does the child have the right to make an independent decision? Should the child of an alcoholic parent be afraid of using alcohol? If a person decides to abstain, either permanently or for the present, how can he or she cope with peer pressure to drink?

The role of the school and of the teacher is to provide the information that youngsters need to make these decisions, to help them examine their own attitudes and feelings, and to develop decision-making skills for application to this and other life choices. The JACKSON JUNIOR HIGH film series and curriculum materials can help achieve these objectives.

About the Films

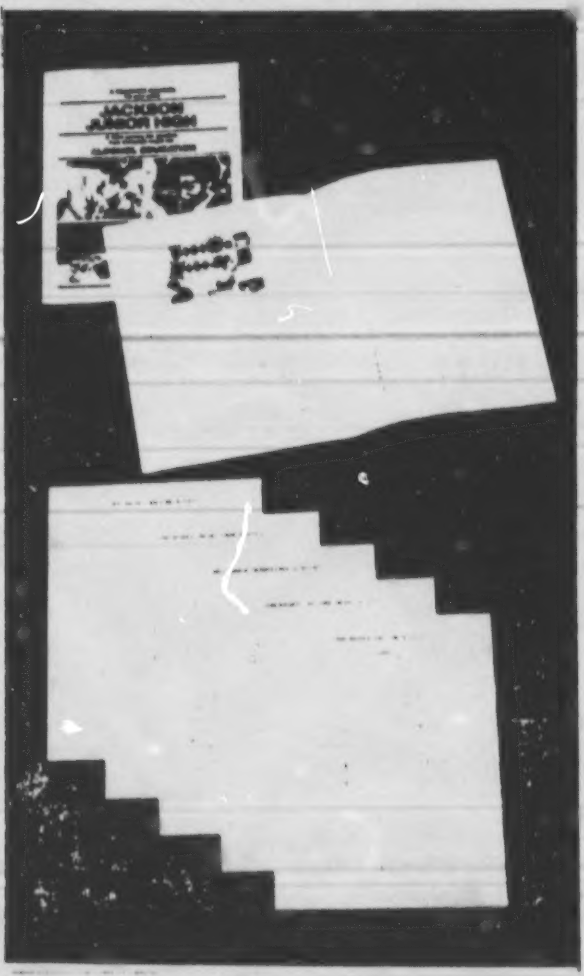
Each film runs for 15 minutes. The Teacher Manual and Student Booklet suggest activities which range in duration from 15 to 45 minutes. Some activities preview key issues in the films; others suggest follow-up activities to be carried out both inside and beyond the classroom.



JACKSON JUNIOR HIGH—*Preview* (13 minutes) — This film is an introduction to the JACKSON JUNIOR HIGH alcohol education series and features excerpts from the four films.

Film Title and Story	*Content and Issues*
Route 1 — Patches has a hangover, no small problem for a 200 lb. St. Bernard. An 8th grade science class begins with his problem as they discuss alcohol's effects. A cartoon sequence follows alcohol through the bloodstream.	Bio-chemical effects of various levels of alcohol intake are presented as are important value-oriented issues including responsibility and the widespread use of alcohol by all ages for purposes of ceremony and celebration.
The Party's Over — Fred crashes Sarah's quiet teen-age party bringing some wine to "liven things up." The result: disruption and antisocial behavior that goes beyond Sarah's ability to cope.	While responsibility and maturity are key issues ("At what age should people be allowed to drink?"), external influences on behavior and attitudes are illustrated. These include parental example and peer pressure.
Barbara Murray — A non-drinking substitute teacher finds herself conducting a class discussion of whether alcohol is "good" or "bad." A cartoon sequence shows the origins and history of beverage alcohol in a variety of cultures.	Much factual information on differing religious and ethnic customs about drinking is provided. This and examples of peer pressure among adults emphasize that drinking or non-drinking should be a matter of conscious personal choice.
Like Father, Like Son? — Young Jim's problem is excessive drinking by his father, who recently lost his job. The boy is studying alcohol at Jackson Junior High and wants to help his dad, but "Big Jim" goes into a rage when the topic is mentioned.	What is "too much" drinking? What is alcoholism, and how can the drinker's friends or family help? What resources exist in the community for the problem drinker and for those whose life he affects? These questions are posed, but your students must research the answers.

Curriculum Materials



The Teacher Manual

The 36-page Teacher Manual that accompanies the JACKSON JUNIOR HIGH film package has two principal objectives. First, it's designed to help the classroom teacher prepare students both to perceive each film's message accurately and to build upon that message in post-viewing work. Second, the Teacher Manual provides background information that will allow the teacher to confidently facilitate class discussion of alcohol, regardless of the teacher's own familiarity with the topic. A comprehensive list of resources for further information is also provided in the manual.

Included with the Teacher Manual are five Spirit Masters so that student hand-out materials can be easily prepared on duplicating equipment available in most schools.

Contents of the Teacher Manual

I. Introduction
Purposes of the Teacher Manual, The Organization of The Teacher Manual, and The Goals of Alcohol Education.

II. Learning Activities for Each Film
How to Use the Activities.
Activities (5 to 7 each) for *Route 1*, *The Party's Over*, *Barbara Murray*, and *Like Father, Like Son?*

III. Background Information on Alcohol and Alcohol Education
Teaching About Alcohol, Youth and Alcohol, Facts About Alcohol and Problem Drinking and Alcoholism.

IV. Resources
Bibliographies of reference materials for use by teachers and students. Also addresses of national organizations dealing with alcohol issues.

V. Spirit Masters
Polls, quizzes, problem-solving exercises.

KIDS AND ALCOHOL

The Student Booklet

The 20-page Student Booklet entitled *Kids and Alcohol* was designed to supplement the films in several ways. "Preview" reading is provided to raise issues which will be handled in the film and to sensitize students to the implication of specific happenings. Still photographs from the motion pictures are used as illustrations. Follow-up readings are included to reinforce and expand upon the message of each film.

The booklet treats youngsters as responsible decision-makers and is a reliable resource of factual material on alcohol and alcohol problems. As with all the materials in the JACKSON JUNIOR HIGH package, an effort has been made to present a balanced view of both the positive and negative aspects of both drinking and abstention in American life. Cartoon drawings are used to convey factual information about alcohol and its effects.

JACKSON JUNIOR HIGH
Curriculum Materials
Teacher Manual, Student Booklets

The Teacher Manual and the Student Booklet are available free from the National Clearinghouse for Alcohol Information (NCALI), while supplies last.

Teacher Manual 36 pp., provides background information on alcohol, list of resources, spirit masters for duplication. Limit — one free manual per order.

Kids and Alcohol, Student Booklet 20 pp., supplements the films, provides factual information on alcohol. Limit — 30 free booklets per order.

Send Teacher Manual and Student Booklet requests to:
NCALI
P.O. Box 2345
Rockville, MD 20852

Additional copies of the Teacher Manual and Student Booklets may be purchased from the National Council on Alcoholism, 733 Third Avenue, New York, NY 10017. Write for prices.

JACKSON JUNIOR HIGH
Curriculum Materials Request Card

☐ Teacher Manual, limit — one free manual per order.

☐ Kids and Alcohol, Student Booklet, limit — 30 free booklets per order.

Name ____________________

Title ____________________

School ____________________

Address ____________________

City ____________ State ____________ Zip ____________

Send orders to: NCALI, P.O. Box 2345, Rockville, MD 20852

☐ Check here if you would like to receive additional materials on alcohol and alcohol abuse.

JACKSON JUNIOR HIGH
Films - Purchase

All the films in the JACKSON JUNIOR HIGH series are available for purchase in 16mm and ¾" videocassette formats from the National Audiovisual Center.

Preview Film	Title No.	Price
16mm	008711	$ 64.50
¾" video	008712	52.50
Route 1		
16mm	008703	73.50
¾" video	008704	52.50
The Party's Over		
16mm	008709	73.50
¾" video	008710	52.50
Barbara Murray		
16mm	008705	73.50
¾" video	008706	52.50
Like Father, Like Son		
16mm	008707	73.50
¾" video	008708	52.50
Entire Series		
16mm	008713	358.50
¾" video	008714	262.50

Make checks payable to:
National Archives Trust Fund (NAC)

Send orders to:
National Audiovisual Center (NAC)
General Services Administration
Order Section
Washington, DC 20409

JACKSON JUNIOR HIGH
Film Purchase Card

Title ____________________ Title No. ____________

No. prints ____________ Total $ ____________

Title ____________________ Title No. ____________

No. prints ____________ Total $ ____________

Title ____________________ Title No. ____________

No. prints ____________ Total $ ____________

Title ____________________ Title No. ____________

No. prints ____________ Total $ ____________

Total enclosed $ ____________

Name ____________________ Title ____________

School ____________________

Address ____________________

City ____________ State ____________ Zip ____________

Phone ____________________

Make checks payable to: National Archives Trust Fund (NAC)

Send orders to: National Audiovisual Center (NAC), General Services Administration, Order Section, Washington, DC 20409

☐ Check here if you would like to receive additional materials on alcohol and alcohol abuse.

NATIONAL CLEARINGHOUSE FOR ALCOHOL INFORMATION

It's Dangerous to Mix Alcohol and Drugs

In recent years, hundreds of new drugs have been introduced for inducing sleep and for tranquilization, sedation, relief of pain, motion sickness, head colds, and allergy symptoms. Too numerous to name, they include narcotics, barbiturates and other hypnotic-sedative drugs, tranquilizers, and antihistamines.

Alcohol is a drug which can produce feelings of well-being, sedation, intoxication, and unconsciousness. Since alcohol works on the same brain areas as some of these other drugs, it can multiply the usual responses normally expected from either the drug or the alcohol alone, if they are taken fairly close to one another. For example, alcohol and barbiturates in combination increase each other's effects on the central nervous system and can be particularly dangerous. Alcohol in combination with any drug that has a depressant effect on the central nervous system likewise represents a special hazard to health and safety — sometimes to life itself. Some understanding of metabolism, i.e., the way our bodies chemically process the things we eat, drink, or take, is necessary to explain this reaction.

If drugs were not metabolized within the body their effect would continue for the remainder of a person's life. In the metabolic process, drugs are transformed into other substances, which are eventually eliminated through normal bodily functions. The more rapid the rate of metabolism, the lower the impact of the drug. When drugs are forced to compete with alcohol for processing by the body, alcohol is metabolized first, while the other drug remains active in the blood for an extended period of time. As a result, the drug's effect on the body is exaggerated, since its metabolism is slowed down due to the body's tendency to take care of the alcohol first. When added to the normal depressant consequence of alcohol, further depression of the nervous system which regulates vital body functions occurs. This is a serious condition that can result in death.

There is another danger, which can also lead to serious problems in persons who habitually drink large amounts of alcohol. As a result of excessive drinking, during periods of sobriety, barbiturates or sedatives will have less effect, since these drugs are more rapidly metabolized. It is therefore not uncommon for heavy drinkers to take ever larger doses of drugs, because the usual quantities taken by non-drinkers or moderate drinkers will have little effect. The results of taking the large doses and then drinking can place these persons in even greater jeopardy and can be fatal.

Think Before You Drink

If you want to take a drink when you are also taking medication, three actions may save you from a serious illness or accident, or may even save your life:

- Read the warnings on non-prescription drug labels or those on your prescription container
- Ask your doctor about possible alcohol/drug interactions
- Check with your pharmacist if you have any questions about your medication, especially those you can buy without a doctor's prescription

What Could Happen if You Drink While Taking Any of These Drugs

The chart below lists classes of drugs which have been reported to interact with alcohol. Some of the dangers that may result from combining alcohol with the other listed drugs are described. If you asked for information on a specific drug, a check-mark has been placed in the box preceding the class of drug which best describes the one for which you requested information. It must be emphasized that this chart, or any other like it, only represents the smallest part of the whole alcohol/drug interaction picture. It is not meant to replace the advice of your family doctor or your pharmacist.

☐ **ANALGESICS, NARCOTIC**
(Demerol, Darvon, Dilaudid, etc.)

When used alone, both alcohol and narcotic drugs cause a reduction in the function of the central nervous system. When used together, this effect is even greater, and may lead to loss of effective breathing function (respiratory arrest). Death may occur.

☐ **ANALGESICS, NON-NARCOTIC**
(Aspirin, APC, Pabalate, etc.)

Even when used alone, some non-prescription pain relievers can cause bleeding in the stomach and intestines. Alcohol also irritates the stomach and can aggravate the bleeding, especially in ulcer patients.

☐ **ANTIALCOHOL PREPARATIONS**
(Antabuse, Calcium Carbimide)

Use of alcohol with medications prescribed to help alcoholic patients keep from drinking results in nausea, vomiting, headache, high blood pressure and possible erratic heart beat, and can result in death.

☐ **ANTICOAGULANTS**
(Coumadin, Dicumarol, Sintrom, etc.)

Alcohol can increase the ability of these drugs to stop blood clotting, which in turn can lead to life-threatening or fatal hemorrhages.

☐ **ANTICONVULSANTS**
(Dilantin, Diphenyl, [illegible], etc.)

Drinking may lessen the ability of this drug to stop convulsions in a person.

☐ **ANTIDEPRESSANTS**
(Tofranil, Pertofrane, Triavil, etc.)

Alcohol may cause an additional reduction in central nervous system functioning and lessen a person's ability to operate normally. Certain antidepressants in combination with red wines like Chianti may cause a high blood pressure crisis.

☐ **ANTIDIABETIC AGENTS/HYPOGLYCEMICS**
(Insulin, Diabinese, Orinase, etc.)

Because of the possible severe reactions to combining alcohol and insulin or the oral antidiabetic agents, and because alcohol interacts unpredictably with them, patients taking any of these medications should avoid alcohol.

☐ **ANTIHISTAMINES**
(most cold remedies, Actifed, Coricidin, etc.)

Taking alcohol with this class of drugs increases their calming effect and a person can feel quite drowsy, making driving and other activities which require alertness more hazardous.

☐ **ANTIHYPERTENSIVE AGENTS**
(Serpasil, Aldomet, Esidrix, etc.)

Alcohol may increase the blood pressure lowering capability of some of these drugs, causing dizziness when a person gets up. Some agents will also cause a reduction in the function of the central nervous system.

☐ **ANTIINFECTIVE AGENTS/ANTIBIOTICS**
(Flagyl, Chloromycetin, Seromycin, etc.)

In combination with alcohol, some may cause nausea, vomiting, and headache, and possibly convulsions, especially those taken for urinary tract infections.

☐ **CENTRAL NERVOUS SYSTEM STIMULANTS**
(most diet pills, Dexedrine, Caffeine, Ritalin, etc.)

Because the stimulant effect of this class of drugs may reverse the depressant effect of the alcohol on the central nervous system, these drugs can give a false sense of security. They do not help intoxicated persons gain control of their movements.

☐ **DIURETICS**
(Diuril, Lasix, [illegible], etc.)

Combining alcohol with diuretics may cause reduction in blood pressure, possibly resulting in dizziness when a person stands up.

☐ **PSYCHOTROPICS**
(Tindal, Mellaril, Thorazine, etc.)

Alcohol and the "major tranquilizers" cause additional depression in central nervous system function, which can result in severe impairment of voluntary movements such as walking or using the hands. The combination can also cause a loss of effective breathing function and can be fatal.

☑ **SEDATIVE HYPNOTICS**
(Doriden, Quaalude, Nembutal, etc.)

Alcohol in combination further reduces the function of the central nervous system, sometimes to the point of coma or the loss of effective breathing (respiratory arrest). This combination can be fatal.

☐ **SLEEP MEDICINES**

It is likely that non-prescription sleeping medicines, to the degree that they are effective, will lead to the same kind of central nervous system depression when combined with alcohol as the minor tranquilizers (see below).

☐ **TRANQUILIZERS - MINOR**
(Miltown, Valium, Librium, etc.)

Tranquilizers in combination with alcohol will cause reduced functions of the central nervous system, especially during the first few weeks of drug use. This results in decreased alertness and judgment, and can lead to household and automotive accidents.

☐ **VITAMINS**

Continuous drinking can keep vitamins from entering the blood stream. However, this situation changes when a person stops drinking.

☐ **OTHER**

Either we have not been able to identify the drug you mentioned, or data are not sufficient to provide an answer. Check with your doctor or pharmacist to be sure.

E CAS7601

State of New York
COMMISSION ON ALCOHOL AND SUBSTANCE
ABUSE PREVENTION AND EDUCATION
Office of Alcoholism and Substance Abuse

Alcohol and Substance Abuse Fact Sheet Series

ALCOHOL: SOME FACTS

Alcohol is the most popular drug in America, Europe and most other parts of the world, with only a few countries prohibiting its use. It is also the drug which causes the most accidents, addictions and deaths. More people in the United States die each year as a result of alcohol than from all illegal drugs combined.

Many people do not feel alcohol is a drug, even though they use it and may sometimes become drunk, or stoned. Others feel that it is a drug, but is a "special" drug that is not at all like the illegal ones. Still other people feel that only strong liquors like Vodka and Scotch are bad for health, but that beer and wine are not harmful. All of these opinions are wrong.

Alcohol is a drug, and a very potent one. Until earlier in the 20th century, it was often used by doctors to kill pain. It was replaced by other drugs for this purpose, however, when better ones were invented.

Alcohol also takes certain vitamins and minerals out of the body, such as Vitamin C, calcium pantothenate, Vitamin A, and others. Alcoholics often have many chronic problems caused by vitamin deficiencies, and even those who drink much less must be careful to watch their vitamin intake.

Alcoholic drinks have some good and many bad uses, all depending on the person involved and how much is used. This is the exact same rule for almost every other drug that can make a person high; it depends on how much, how often, and the personality type of the user, plus other factors. The substance itself is just like any other drug, neither good nor bad. Alcohol in small amounts can make many people relax, or help overcome a feeling of being nervous at a party or dinner. But there are other techniques for relaxing that may work just as well if you learn them, such as mental exercises, and breathing techniques.

Sometimes people try to get rid of their problems by drinking. This works at first, but only when you are drinking, and the next day the problems come back again. After awhile there is a new problem on top of the old one: Alcoholism. This is an addiction that acts in much the same way as addiction to other drugs, such as heroin and barbiturates. The addicted person cannot go for very long without more and more of the drug. If the drug is stopped, then withdrawal starts. There is pain, and a danger of grand mal (large) convulsions, which are sometimes deadly unless a doctor is helping the withdrawal in a hospital.

Alcohol causes overdoses very often. It also makes people sick when they drink too much. Sometimes people get sick and then throw up after they pass out, which can be very dangerous. If a person has passed out he/she may be facing upward, sleeping. Then if they throw up, they may inhale it and suffocate without waking up. It is always safest to place a person who has passed out after drinking on their stomach, with the head turned so that this type of suffocation cannot happen.

It is also deadly to drink and use other drugs at the same time. This is a problem with people who use legal drugs as well as the illegal ones. Alcohol should never be used if a person is taking sleeping pills of any kind (usually barbiturates), Valium, Librium, methaqualone (Quaaludes, Sopors, etc.), PCP or Angel Dust, Thorazine, Stellazine, Elavil, Triavil, and other drugs which are either mild or heavy downers, including heroin.

The problem with mixing drugs is that the liver cannot filter out the drugs at the normal rate, since it is also working hard to get rid of the alcohol. People die of overdoses since their bodies cannot handle both chemicals at the same time, and a reaction takes place that makes the drugs seem stronger than they originally were. The number of drugs needed, and the amount of alcohol used to overdose, is different for every person.

You may hear of people who believe in strict abstinence. That is, they never drink even a little bit. This is of course a good idea, but it may not be right for everybody. There is no evidence that occasional use of alcohol of any kind, in small amounts, will be harmful. You should make up your mind about this on your own, and not as a result of pressure. Drinking because someone tells you to is never a good thing, either.

What if your parents use alcohol, but insist this is all right for them, but not for you? Many parents feel that alcohol should not be used by their children until they are legally old enough for it according to the law.

Other parents see alcohol use as all right for their children on occasion (a taste sometimes), but do not feel it is a drug. Therefore, they may say that it is all right for them to use alcohol, and for you to find out about it, but they warn you to never use drugs. This is because they see the difference between a "good" drug and a "bad" drug according to whether it is illegal.

Many different kinds of opinions exist about alcohol and every other type of legal or illegal drug. New facts are always being discovered. So what people used to believe was true is not always true today.

It is known today that many young people who have one or both parents who suffer from alcoholism may tend to be alcoholics themselves later in life. Special help is available from a group called Alateen, a division of Al-Anon, an organization for families of alcoholics. There are chapters in many areas. Alcoholics Anonymous or your local alcohol organization will be able to identify the nearest Alateen chapter.

It is hard to say what attitudes everyone's parents will have. Hopefully your parents will want to discuss alcohol facts and drug facts and give you good reasons for everything discussed. If not, it is up to you to learn all you can.

For more information about alcohol, write or call your local chapter of the National Council on Alcoholism, or write to the National Institute on Alcohol Abuse and Alcoholism, Box 2345, Rockville MD 20852.

In New York State, more information about alcoholism can be obtained by writing the NYS Division of Alcoholism, 44 Holland Ave., Albany NY 12229.

This fact sheet printed by CASAPE, Box 8200, Albany NY 12203. More information on request. FS105. Reprints available.

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NATIONAL CLEARINGHOUSE FOR ALCOHOL INFORMATION

PUBLICATIONS ORDER FORM

The National Clearinghouse for Alcohol Information (NCALI) distributes alcohol-related pamphlets, books, posters and other materials published by the National Institute on Alcohol Abuse and Alcoholism. Listed below are some of the informational items available from NCALI. If you would like to receive a copy of any of these items, check the box next to the title. Limited quantities of these materials are available free of charge. If you are interested in obtaining large quantities of any of the items, please so indicate and we will send you details on how and where to obtain them. If you are interested in more information on other NCALI services, simply write a letter detailing your request. We will be pleased to take care of your further alcohol information needs.

ORGANIZATION

LAST NAME FIRST

OCCUPATION

STREET ADDRESS

CITY

STATE ZIP COUNTRY

☐ NIAAA INFORMATION AND FEATURE SERVICE. This news service presents articles on trends, opinions, and programs across the nation, highlights the activities of the NIAAA and other alcoholism organizations, and spotlights topics of special interest. It is designed so that articles can be easily reproduced by other publications. There is no charge for a subscription to this publication; check the box to have your name placed on the mailing list.

☐ [illegible]7903 ALCOHOL HEALTH AND RESEARCH WORLD. Intended for all professionals involved in the treatment, research and prevention of alcohol abuse and alcoholism, this periodic bulletin provides in-depth coverage of specific topics related to alcohol. THIS IS A PAID SUBSCRIPTION PUBLICATION: CHECK THE BOX FOR MORE INFORMATION AND A SUBSCRIPTION ORDER FORM.

PUBLICATIONS

☐ DT415 HOW TO TALK TO YOUR TEENAGER ABOUT DRINKING AND DRIVING. Offers facts about drinking as well as specific guidelines for parents in discussing alcohol use with their high school age children. 12 pp.

☐ DT911 AN ACTIVIST'S GUIDE FOR CURBING THE DRUNK DRIVER. Provides factual information about the hazards of drinking and driving. 12pp.

☐ PH73 ALCOHOL ABUSE AND WOMEN: A GUIDE TO GETTING HELP. Offers support and treatment information for the woman with an alcohol problem, with emphasis on the particular difficulties faced by the woman problem drinker. 25 pp.

☐ PH86 THE UNSEEN CRISIS: BLACKS AND ALCOHOL. A general audience brochure designed to increase awareness among black Americans of alcohol problems in their community. 15 pp.

☐ PH90 ALCOHOL AND YOUR UNBORN BABY. The risks and potential effects of heavy drinking on the unborn baby are identified to help mothers and families make the best informed, personal decisions concerning alcohol use during pregnancy. 16 pp.

☐ PH108 TREATING ALCOHOLISM: THE ILLNESS, THE SYMPTOMS, THE TREATMENT. Causes and symptoms of alcoholism and its effects on the body are described along with types of therapies and treatment facilities. National organizations and other sources for additional information are named. 16 pp.

☐ PH116 UNAMOS NUESTROS ESFUERZOS....EL ALCOHOLISMO ES UN PROBLEMA DE TODA LA FAMILIA. Bilingual Publication. Discusses alcoholism as a family problem; explains alcoholism, warning signs, how to assist a family member and where to go for assistance.

See other side for continuation

☐ PH117 TU DECISION. Bilingual Publication. Aimed at the Hispanic young. Explains the effects of alcohol on the mind and body; discusses warning signals and machismo; stresses decision-making.

☐ MS33 AGENCIAS Y CONTACTOS EN LOS ESTADOS ACERCA DE ALCOHOLISMO Y LOS HISPANOS

☐ PH119 HABLEMOS EN CLARO...ALGUNAS PREGUNTAS Y RESPUESTAS SOBRE EL ALCOHOLISMO. Bilingual Publication. Details what is alcoholism, its symptoms, how it affects personality and the body, sources for treatment and assistance.

☐ PH120 DE MUJER A MUJER..HABLEMOS SOBRE EL ALCOHOLISMO. Bilingual Publication. Alcoholism is discussed from the point of view of Hispanic women. Explains treatment and information sources and facilities.

☐ BK72 THE WHOLE COLLEGE CATALOG ABOUT DRINKING. Focuses on alcohol use and abuse on the college level and suggests prevention programming strategies for affecting the problem. 129 pp.

☐ PH22 THE ANSWER BOOK. Answers to the most commonly asked questions concerning alcohol use, abuse, prevention and treatment. 11 pp.

☐ PH23 DRINKING ETIQUETTE. Takes a look at the ways people drink and proposes some guidelines to help host, hostess, and guest develop a drinking etiquette thereby avoiding many of the problems which come with unwise drinking. 13 pp.

☐ PH24 THE DRINKING QUESTION. Addresses questions teenagers ask about drinking. Answers are concise and factual but non-technical. It is suitable for use by teenagers and parents. 28 pp

☐ PH92 FACING UP TO ALCOHOLISM. The recovery process is detailed for persons who may have developed a drinking problem. 11 pp.

☐ PH95 IS BEER A FOUR LETTER WORD? Contains project ideas, materials, suggestions and alcohol education concepts from many sources across the country. The purpose of Is Beer a Four Letter Word? is to interest young people in alcohol-related issues which affect them, and to encourage them to initiate alcohol abuse prevention projects. 60 pp.(2 copy limit)

☐ PH104 SOMEONE CLOSE DRINKS TOO MUCH. Suggestions are offered on how a person can play a key role in the turnabout, treatment, and recovery of "someone close" with an alcohol problem. 13 pp.

☐ PH105 ALCOHOL: SOME QUESTIONS AND ANSWERS. Briefly answers several questions concerning the affects of alcohol on the body and the reasons why people drink. 14 pp.

☐ PH111 HOW TO HELP: WHAT YOU CAN DO TO HELP YOUR COMMUNITY HELP ALCOHOLIC PEOPLE. Suggest ways to initiate and implement change in alcoholism services on a local level. 16 pp.

☐ PH158 TEACHING ABOUT DRINKING. Suggests classroom techniques for encouraging safe drinking attitudes. 10 pp.

☐ DR DIRECTORY OF TREATMENT RESOURCES. Indicate the state for which you would like to receive a directory.
DR______________________.

☐ DR26 NATIONWIDE DIRECTORY OF OCCUPATIONAL ALCOHOLISM CONSULTANTS.

☐ MS140 DIRECTORY OF STATE AND TERRITORIAL ALCOHOLISM AUTHORITIES AND PROGRAM DIRECTORS

POSTERS

☐ AV88.5 If You Drink a Lot of Beer 14" x 17", color

☐ AV88.6 Typical Alcoholic 14" x 17", color

☐ AV88.7 Getting Drunk 14" x 17", color

☐ AV100.1 Alcohol and Your Unborn Baby 14½" x 23¾" color

☐ AV88.8 SALUD...SALUD? (POSTER). Lists in Spanish the major warning signs of alcoholism. Size, 20" x 30".

☐ AV88.9 TU DECISION (POSTER). Bilingual message designed to inform Hispanic youth on decision making about drinking. Size, 20" x 30".

☐ AV99 POSTERS. Complete set 18" x 23", black and white, targeted to black Americans. Individual posters listed below.

AV99.1 Reverend Jesse Jackson
AV99.2 Physical Fitness
AV99.3 School
AV99.4 What Kind of Example
AV99.5 My Baby

Mail completed form to: NCALI P.O. Box 2345 Rockville, MD. 20852

DRUGS - PAMPHLETS & REPORTS

Addiction & Drug Abuse Report

A Service of: Grafton Publication Inc.
667 Madison Ave
New York, NY 10021

A Follow-up Study of Teachers Trained In
Affective Classroom Approaches To Primary
Prevention of Drug & Alcohol Abuse.
by P. Bandt, J. Hammond, T. Widso and A. Mitzel. 1976

Governor's Council on Drug & Alcohol Abuse
Riverside Office Bldg.
2101 North Front Street
Harrisburg, PA 17120

Amphetamines - The Stimulant Drugs

Drug Abuse Prevention Centers
677 South Salina Street
Syracuse, NY
(315-474-5951)

An Investigation of Selected Rural Drug Abuse Programs

Department of Health & Human Services
Alcohol, Drug Abuse & Mental Health Adm.
5600 Fishers Lane
Rockville, MD 20857

A Review and Summary of Reports by the Addictions Laboratory.
by C.E. Earl 1979

Governor's Council on Drug & Alcohol Abuse
Riverside Office Bldg.
2101 North Front Street
Harrisburg, PA 17120

Barbituates - The Depressant Drugs

Drug Abuse Prevention Centers
677 South Salina Street
Syracuse, NY
(315-474-5951)

Drug Abuse - Drugs in a Chemical Dependent Society

Write: Blue Cross/Blue Shield
622 Third Ave
New York, NY 10017

Drug Abuse Information Kit

Write: Eli Lilly and Company
Indianapolis, Indiana

Drug Abuse Prevention
D.H.E.W. Pub. No. ADM 79-588

National Institute of Drug Abuse
5600 Fishers Lane
Rockville, MD 20857

Drug Abuse the Chemical Cop-Out

Blue Cross/Blue Shield
622 Third Ave.
New York, NY 10017

Drug & Alcohol Abuse in Booming and Depressed Communities

National Institute on Drug Abuse
5600 Fisher Lane
Rockville, MD 20857

Drugs & Driving

Narcotics Education Inc.
Box 4390
6830 Laurel St. S.W.
Washington, D.C. 20012

Drug Enforcement Administrative Prevention Programs
Washington, DC 20537 or
GPO, Washington, DC 20402

Excellent 44-page magazine with articles and pictures on health hazards and articles on drug paraphernalia. Single copies free.

Guidelines for School Programs In the Prevention of Drug Abuse

The University of the State of New York
The State Education Department
Special Unit on Health & Drug Education
Albany, NY

Health Consequences of Marijuana Use - Jan. 16, 17, 1980

One Copy free from: Office of Senatory Mathias
Russell Senate Office Bldg.
Washington, D.C. 20510

Homer Drug & Alcohol Awareness Week 1980
by The Homer Parent Group
Phyllis Wainman and Judy Szymalak Co-Chairpersons
Homer, NY 13077

Information on Commonly Abused Drugs - Hazeldon

Contains recommended resources and reading.
National Drug Abuse Foundation
6500 Randall Place
Falls Church, VA 22044
$2.00

"It Starts With People" (Free Booklet)

National Clearinghouse For Drug Abuse Information
Room 10 A - 56, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Marijuana and Its Effects
by W. R. Soence M.D.

Spenco Medical Corporation
P.O. Box 8113
Waco, Texas 76710
(1-800-433-334)

Marijuana - Facts, Figures and Information for the 1980's.
by Brent Q. Hafen Ph.D. and Kathryn J. Franden

Hazeldon Education Services
Box 176
Center City, MN 55012

Narcotics Identification Guide
Slide Card

U.S. Army Recruiting Command
Hampton, Virginia 23369

New York State Marijuana Law -
Questions & Answers

Legislative Office Building
Room 659
Albany, NY 12248
(518-455-4477)

Our Most Dangerous Drug
Reprint from Listen, Journal of Better Living

Narcotics Education Inc.
6830 Laurel St. N.W.
Washington, D.C. 20012

P.C.P
D.H.E.W. Pub. No. (ADM) 79-805

Alcohol, Drug Abuse & Mental Health Administration
5600 Fishers Lane
Rockville, MD 20857

Saying No - Drug Abuse Prevention Ideas for the Classroom
D.H.E.W. Pub. No. (ADM) 80-916

Alcohol, Drug Abuse & Mental Health Administration
5600 Fishers Lane
Rockville, MD 20857

Smoking & Health Bulletin

U.S. Dept. of Health & Human Services
Public Health Services
Office of the Assistant Secretary of Health
Office on Smoking & Health
Rockville, MD 20857

Teacher Resource Instructional Packet
System in Drug Education
by D.F. Meyer & J.D. Swisher 1975

Governor's Council on Drug & Alcohol Abuse
Riverside Office Bldg.
2101 North Front Street
Harrisburg, PA 17120

The Drug Society

Remarks by Art Linkletter at the White House before a bipartisian leadership discussion on the narcotics problem.

National Teenage Republicans
359 National Press Bldg.
Washington, D.C. 20004
(202-737-0176)

This Side Up - Making Decisions About Drugs
DHEW Publication No. ADM 79-420 Printed 1979

National Institute on Drug Abuse
Office of Communications & Public Affairs
5600 Fishers Lane
Rockville, MD 20857

What About Drugs & Employees

Public Relations Dept.
Kemper & Insurance
Long Grove, IL 65049

DRUGS - BOOKS

Balancing Head and Heart: Sensible Ideas for the Prevention of Drug and Alcohol Abuse
by E. Schaps

Pacific Institute for Research and Evaluation
Walnut Creek, CA

(A three volume series based on a developmental approach to drug and alcohol abuse)

Drug Abuse from the Family Perspective
(No. ADM 80-910)

Dept. of Health and Human Services
Alcohol, Drug Abuse & Mental Health Administration
5600 Fisher Lane
Rockville, MD 20857

Drugs From A to Z - A Dictionary
by Richard R. Lingeman

McGraw Hill Book Co. Cost $4.95
New York, NY

How To Talk to Kids About Drugs
Cost $2.50

Potomac Press
Pacific Institude for Research & Evaluation
7101 Wisconsin Ave, Suite 1006
Bethesda, MD 20014

Keep off the Grass: A Scientific Inquiry into the Biological affects of Marijuara
by Gabriel G. Nahas, M.D., Ph.D.
Cost $9.50 (259 pages)

Pengamon Press, Inc.
Maxwell House
Fairview Park
Elmsford, NY 10525

Marijuana Today: A Compilation of Medical Findings for the Layman
by George K. Russell

Distributed by the Myrin Institute for Adult Education
521 Park Ave
New York, NY 10021

Parents, Peers & Pot
by Marsha Manatt, Ph.D.
(Free) (98 pages)

National Clearinghouse For Drug Abuse Information
Room 10 A -56, Parklawn Building
5600 Fisher Lane
Rockville, MD 20857

President of the sixth Essex County Grand Jury of the 1978 Term
by Richard Roberts, Assistant Prosecutor of Essex County, New Jersey

Detailed report of drug use in Schools includes
specific recommendations
Cost $5.00 (60 pages)

Essex County Prosecutor
New Courts Building
Newark, NJ 07102

Reaching Out: The Prevention of Drug Abuse Through Increased Human Interaction
by Gerald Edwards

IDEP Inc.
Innovative Designs for Educational Action Inc.
Garden City, NY

Sensual Drugs, Deprivation and Rehabilitation of the Mind
by Hardin & Helen Jones 1977
Cost $6.95 (373 pages)

Cambridge University Press
32 East 57th Street
New York, NY 10022

Teaching About Drugs Curriculum Guide K-12

American School Health Association
A.S.H.A. Building
Kent, OH

Drug & Alcohol Abuse Implications for Treatment

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, MD 20857

Drug Abuse and the Growing Child

Mini-Courses
4290 Raintree Lane NW
Atlanta, GA 30327

Six-unit teaching manual for third through eighth grades (for schools, homes and agencies). $10.00.
Cassette with narration, plus 80 color slides showing you methods $46.75

Marijuana Today
by George Russell, Ph.D.

American Council on Marijuana (ACM)
767 Fifth Avenue
New York, NY 10022

Medical findings for the layman
$3.00

The following Books are available through (HIRC) BOCES:

Basic Concepts of Drugs - Their Use & Abuse

Drugs

Drugs From A-Z: A Dictionary

Facing the facts: Drugs, Alcohol & Tobacco

Resource Book for Drug Abuse Education (Second Edition)

National Clearinghouse for Drug Abuse Information
5600 Fishers Lane
Rockville, MD 20857

The Drug Scene

What You Should Know About Drugs
by Dr. Charles W. Gorodetsky and Dr. Samual T. Christian

Harcourt Brace Jovanovich, Inc.
School Dept. Offices
757 3rd Ave
New York, NY 10017

DRUGS - POSTERS & STICKERS

"Four Ways You Can Help Stop Drug Abuse Before It Starts"

"The Name of the Game Is - DRUG Abuse Prevention Anyone Can Play"

Prevention
Box 170
Washington, D.C. 20013

"Happiness is: NO Dope"

Youth Action today for a better tomorrow.

Smartest - Smarteens, Inc.
1680 N. Vine Street
Hollywood, CA 90027

"The Best Time To Stop Drug Abuse is Before It Starts"

Friend
Box 170
Washington, D.C. 20013

The SPARK Idea: Schools Can Help Drug Abusers

The federal government is tentatively adopting the proposition that drug abuse education can work—for some youth for some objectives. The model currently being touted in federal circles is a school-based program aimed at special groups and attacking a whole range of school-and community-related problems.

Looking to the schools as a possible vehicle for successful drug abuse prevention represents a marked shift in policy and belief. Educators, researchers, and federal administrators alike have been skeptical about the worth of classroom-oriented drug education programs. The National Commission on Marihuana and Drug Abuse felt that drug education in schools was in such a questionable state it suggested declaring a moratorium on all drug education programs in schools "at least until programs already in operation have been evaluated and a coherent approach, with realistic objectives, has been developed." Programs telling youngsters not to experiment with drugs simply do not do the job, the Commission said.

New Policy Shows Turnabout

Signaling a significant policy change, the President's Special Action on Drug Abuse Prevention in a recent paper said, "A key element in altering policy in the United States as far as drug abuse education is concerned is the recognition that drug abuse is not randomly scattered through the school population, but is rather concentrated in a subgroup of students who reflect a cluster of dysfunctional social behaviors including truancy, poor grades, and disciplinary problems.

The Special Action Office, the unit set up by the President to coordinate and consolidate federal drug abuse prevention efforts, went on to say that by focusing drug prevention efforts on such groups and by dealing with the basic causes of social maladjustment drug abuse programs can successfully alter behavior.

The Office is now studying five or six programs around the country that operate on a similar rationale as a prelude to a possible major federal evaluation and pilot demonstration effort. One New York City program—"one of the more creative drug programs in the country," in the words of the Special Action Office paper—is under study. The New York program is popularly known as SPARK, an acronym for "School Prevention of Addiction Through Rehabilitation and Knowledge."

The locally supported SPARK program has four basic components. First, the program sets up in each of the city's 94 high schools one drug education specialist—usually a specially trained certified classroom teacher. Second, in 40 schools with high incidence of drug abuse, a second person—a community worker, possibly an ex-addict himself—is added to the team. In addition, a core of 200 students is specially trained to work with the drug education specialists throughout the high schools. Finally, nine high schools with extremely high need have "intervention prevention" teams. These teams are made up of six staff members, including a psychologist or social worker, guidance counselor, attendance teacher, classroom teacher and two neighborhood workers.

The major activity in all schools is counseling —either on an individual basis, in regular small group sessions, or in semiformal rap sessions.

Groups Tend to Become Close-Knit

Both peer group pressure and group support are seen as important factors in changing behavior. Some of the groups become so close-knit, they refer to themselves as The Family, The Brotherhood, or The People's Center.

Besides group and individual counseling sessions, SPARK identifies and refers drug abusers for treatment, trains students for group leadership roles, makes home visits, sponsors parent workshops and runs parent-child group sessions. SPARK team members can also be found accompanying emergency drug abuse cases to local hospitals, visiting "feeder" junior high schools, meeting returning runaways at the airport in the middle of the night, and conducting poetry, guitar, karate, or yoga therapy. SPARK also works with teachers, providing them information, resource materials, and training in drug abuse prevention.

Several Positive Effects Noted

The SPARK approach seems to pay off. A recent study of 900 students in nine high schools participating in counseling sessions showed a 28 percent reduction in absenteeism; a 49.3 percent reduction in disciplinary referrals; a 66.5 percent reduction in unsatisfactory conduct ratings; a 38.5 percent reduction in major subjects failed, and an increase of slightly over six points on their overall grade-point average.

SPARK's impact on school life can be measured in other ways as well. In 1970-71, before the program got under way, the nine schools surveyed had to call for ambulances 59 times because of student drug-related problems. Last year, the number of ambulance calls for the nine schools dropped to 12.

NYS DIVISION OF SUBSTANCE ABUSE SERVICES
Bureau of Training and Resource Development

RESOURCE CENTER

The Bureau of Training and Resource Development provides training and other educational opportunities to those involved in providing service related to substance abuse in New York State. One of the 'other' educational opportunities is the library services of the Resource Center which provides people concerned with substance abuse the opportunity to study and do research on their own.

Location and Operating Hours

The Resource Center is located at 95 Madison Avenue, 3rd Floor, NYC, 10016. It is open from 9:00 am to 5:00 pm, Monday thru Friday. The telephone number is (212) 679-3733.

Rules and Procedures

All materials in the Resource Center are cataloged by author, title, and subject(s) and a card catalog provides access to the material.

The services and resources are available to employees of substance abuse agencies in New York State as well as people employed in related fields. Borrowing privileges are extended to persons who have filled out a borrowers form and who have thus agreed to return borrowed materials. Computer-generated bibliographies are developed when other sources of information are exhausted and/or are not available.

The general public is welcome to visit and study in the Resource Center and obtain free NIDA publications.

To request information - call, write or visit the Resource Center. Materials will be sent to you anywhere in New York State and borrowed items may be returned by mail.

Services and Resources

Free loan of books for 4 weeks	2000 + books
Free photocopies of journal articles and other reference materials	Subscriptions to the primary journals and newsletters in the field of substance abuse
Interlibrary loans processed to obtain requested material not owned by the Resource Center	Approximately 6000 reprints of journal articles plus pamphlets and reports
Reading room for research and study. A microfiche reader is available for use	Over 250 documents on microfiche
Distribution of free booklets posters and other information materials for the professional and the public	Books, booklets, pamphlets and posters, published by NIDA
Preparation and loan of subject bibliographies	Access to computerized index to the journal literature in most subject areas (i.e., psychology, sociology, education, medicine, etc., etc.)

TEACHER & AGENCY ORDER FORM

DRUG & ALCOHOL PREVENTION & EDUCATION PUBLICATIONS

Materials available from: NYS COMMISSION ON ALCOHOL AND SUBSTANCE ABUSE PREVENTION & EDUCATION

MAIL TO: CASAPE, BOX 8200, ALBANY NY 12203.
Or phone (518) 457-7425.

(Out of date 1/1/80)

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1. HANDOUTS AVAILABLE IN GREATER THAN SINGLE COPY QUANTITIES: Number at end of line denotes maximum allowable. All requests depend on current availability.

_____FS101. PCP Fact Sheet. (Technical, not for general public). DSAS. 1-25.
_____FS102. Sniffing Fact Sheet (JrHS). CASAPE. 1-100.
_____FS103. PCP & Angel Dust Fact Sheet. (JrHS). CASAPE. 1-100
_____FS104. Barbiturate Fact Sheet. (JrHS). CASAPE. 1-100.
_____FS105. Alcohol Fact Sheet. (JrHS). CASAPE. 1-100.
_____FS106. Marijuana Fact Sheet (JrHS). CASAPE. 1-100.
_____FS110. Heroin Fact Sheet.(JrHS). CASAPE. 1-100.

_____Recipes for Non-Alcoholic Party Drinks. Wisc. Clearinghouse. 1-10.
_____PCP Pamphlet. (HS-Adult). NIDA. 1-5.
_____Marijuana: The New Law. DSAS. 1-100.
_____Alcohol & Your Unborn Baby. NIAAA. 1- 3
_____Student Order Forms/Literature Requests, Blanks which can be filled in by subject and returned to CASAPE directly by students doing school reports, etc., or adults. 1-200.

2. HANDOUTS AVAILABLE IN SINGLE COPIES ONLY.

_____Let's Talk About Drug Abuse: Some Questions & Answers. NIDA 1979.
_____Alcohol: What Are We Preventing (Professionals, not for public). CASAPE.
_____Prevention Pursuits Newsletter subscription. CASAPE.
_____A Woman's Choice: Deciding About Drugs: NIDA. (Adults)
_____Annual Report, 1978, NYS Office of Alcoholism & Substance Abuse.
_____Amyl & Butyl Nitrite pamphlet. Do It Now Fdn,
_____Katy the Kangaroo Coloring Book. (Lower Elem.) Prescription drugs. DEA.
_____Drinking & Pregnancy Poster. NIAAA.
_____1979 New York State Drug Laws. (Technical/legal)
_____List of Films Available on Loan. (CASAPE, NIDA Focus on Youth, etc.)
_____NIAAA List of Free Publications.(Alcoholism, Alcohol Subjects)

_____Super Me/Super Yo. Primary Prevention bi-lingual. Eng./Span. younger readers. NIDA.
_____Alcohol/Tobacco/Drugs Annotated Resource Guide. (Teachers), NYState Ed. Dept.
_____School Drug Use Survey, Grades 7-12, Nov, 1978. DSAS.

_____NIDA Prevention posters, two diff. (two girls, black youths)
_____Drug Abuse Prevention booklet (general audience). NIDA.
_____Drug Abuse Prevention for You & Your Friends. (Students). NIDA
_____Drug Abuse Prevention for Your Community. (Adults). NIDA.
_____Drug Abuse Prevention for Your Family. (Parents.). NIDA.
_____"La Prevencion del Abuso de las Drogas." (Prevention, gen. audience, Spanish). NIDA.
_____To Smoke or Not to Smoke booklet. Channing L. Bete Co.
_____ABC's of Drinking & Driving booklet. Channing L. Bete Co.
_____Elder Ed packet: "Using Medicines Wisely." (Sr. Citizens). NIDA.
_____Marijuana and Driving. (General Audience.) Reader's Digest Reprint, 1979.
_____How to Talk to Your Teenager About Drinking and Driving. (Parents). NIAAA.
_____The Drinking Question. (Teenagers.) NIAAA.
_____The Answer Book. (Alcohol questions, general audience). NIAAA.
_____Tu Decision. (English & Spanish, alcohol info.) NIAAA.

_____It's My Life. (Elementary, primary prevention.) Add. Res. Fdn., Canada.

______What Everyone Should Know About Alcohol. Channing L. Bete Co.

______Guide to Alcohol and Drug Abuse Audio-Visual and Print Sources About the Spanish Speaking: In Spanish, English or Bi-Lingual. Do It Now Fdn., Joe Partansky.

______Conscientious Guide to Drug Abuse (Current users & experimenters, HS-Adult). Int. Health Projects.

______Guide for the Family of an Alcoholic. Al-Anon.

______PCP Bibliography. Int. Health Projects.

______Drinking, Smoking & Pregnancy. Int. Health Projects

______Mix & Match: Guide to Deadly Alcohol-Drug Combinations. Int. Health Proj.

______Alcohol: The Number One Drug booklet. (JHS). Wisc. Clearinghouse.

______Party Poster promoting non-alcoholic drinks at parties. Wisc. Clearinghouse. (Adult.)

______PCP: From Street Ripoff to Drug of Choice. (HS). Do It Now Fdn.

______True Facts About Sniffing. (JHS). Do It Now Fdn.

______Gunk: All About Drugs & Pollution. (Grade 5-JHS). Do It Now Fdn.

______Tobacco Abuse. (HS-Adult, aimed at current users.) Do It Now Fdn.

______Alcohol: How it can Affect Health, Nutrition, Vitamins. (JHS-Adult.) Do It Now Fdn.

______Alcohol/Drug Combinations. (HS-Adult). Do It Now Fdn.

______Substance Use and Safety. (HS-Adult). Do It Now Fdn.

______Valium & Librium pamphlet. Do It Now Fdn.

______History & Use of Opiates. Do It Now Fdn.

______Aspirin: Uses and Abuses. (HS-Adult.) Do It Now Fdn.

______Facts About Angel Dust. (JHS). Do It Now Fdn.

______Dados Sobre Polvo de Angel. (JHS). Do It Now Fdn.

______Poison/Overdose/Bummer procedures bookmark. Do It Now Fdn.

______Quaaludes & Sopors pamphlet. Do It Now Fdn.

______"Believe it or Die" drug facts poster. Uses humor & factual info. Do It Now Fdn.

______Sniffing Gunk (Inhalants) poster, elem. & Jr. H.S. level. Do It Now Fdn.

______All About Cocaine. Do It Now Fdn.

4. Other services

______Resource Identification Packet. Contains one each of about 50 different printed items. All CASAPE regular quantity handouts, samples of various publications and periodicals not listed, plus catalogs, pricelists, etc., of good suppliers of alcohol and substance abuse materials & films.

______Special information not listed above on the following subject(s):

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* * *

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Comments... Marijuana and Children - An Interview with Dr. William Pollin, Director, NIDA
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Doing Drug Education
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Drugs and Driving Flyer
Elder Ed
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1st National Asian American Conference on Drug Abuse Prevention-February 20-21, 1976
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Indian In the Red: Reality or Myth?
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It Starts With People
La Prevencion del Abuso de Drogas
Let's Talk About Drug Abuse
Marijuana: Que Es Y Que Hace?
Marijuana: What It *Is* and What It Does
Multicultural Perspectives on Drug Abuse and Its Prevention: A Resource Book
Parents, Peers, and Pot
PCP Flyer
PCP Flyer (Spanish)
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A Needs Assessment Workbook for Prevention Planning Volume II
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Teen Involvement for Drug Abuse Prevention
Teen Involvement for Drug Abuse Prevention: Administrator's Guide
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This Side Up Flyer
What Do They Call It Again?
What Life Will We Make for Our Children
Want Some Straight Talk on Drugs?

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Drug Abuse Instrument Handbook, Issue 12
Data Analysis Strategies and Designs for Substance Abuse Research, Issue 13
Cocaine - Summaries of Psychosocial Research, Issue 15
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Drug Users and the Criminal Justice System, Issue 18
Drugs and Psychopathology, Issue 19
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Research Issues Update 1978, Issue 22
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SPECIAL BIBLIOGRAPHIES - A series of annotated bibliographies for the professional or technical audience on current topics of interest.

Methadone and Pregnancy

TECHNICAL PAPERS - A new series of scientific reviews for the professional or technical audience on drug abuse research issues.

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Cost Accountability in Drug Abuse Prevention
Criminal Charges and Drug Use Patterns on Arrestees in the District of Columbia
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SPECIAL REPORTS

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- Addicted Women: Family Dynamics, Self Perceptions, and Support Services
- Alcohol and Drug Abuse in Medical Education
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- Cabinet Committee on Drug Abuse Prevention, Treatment, and Rehabilitation - Report of the Subcommittee on Prevention
- A Case Study - Narcotic Addiction Over a Quarter of a Century in a Major American City 1950-1977
- Chemistry and Toxicology of Paraquat Contaminated Marihuana: Final Report June 1978
- Cocaine Testimony - By Robert C. Peterson, Ph.D., before the Select Committee on Narcotics Abuse and Control, House of Representatives, July 24, 1979
- Community and Legal Responses to Drug Paraphernalia
- Community Factors, Racial Composition of Drug Abuse Treatment Programs and Outcomes
- Comparative Effectiveness of Drug Abuse Treatment Modalities
- A Comparison of Mental Health Treatment Center and Drug Abuse Treatment Center Approaches to Nonopiate Drug Abuse
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- Drug Abuse Patterns Among Young Polydrug Users and Urban Appalachian Youths
- Drug Abuse: A Technical Assistance Manual for Health Systems Agencies
- Drug and Alcohol Abuse in Booming and Depressed Communities
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Drug Treatment in New York City and Washington, D.C. - Followup Studies
Drug Use and the Elderly: Perspectives and Issues
Drug Use In Industry
Drug Use Patterns, Consequences and the Federal Response: A Policy Review March 1978
Drugs and the Class of '78: Behaviors, Attitudes, and Recent National Trends
Emergency Treatment of the Drug Abusing Patient for Treatment Staff Physicians, Medical Monograph
Ethnography: A Research Tool for Policymakers in the Drug and Alcohol Fields
An Evaluation of Drug Abuse Treatments Based on First Year Followup
An Evaluation of the Teen Challenge Program
Evaluation of California Civil Addict Program
Family Therapy: A Summary of Selected Literature
Federal Strategy for Drug Abuse Prevention 1976
Federal Strategy for Drug Abuse and Drug Traffic Prevention 1979
A Guide to the Investigation of Drug Abuse Deaths
Handbook on Drug Abuse
Health Planning Technical Assistance Manual for Alcohol and Drug Abuse Agencies
Heroin Addicted Parents and Their Children Two Reports
Heroin Indicators Trend Report - An Update 1976-1978
Highlights From Student Drug Use in America 1975-1980
Highlights From the National Survey on Drug Abuse: 1977
Highlights From the National Survey on Drug Abuse: 1979
Illicit Drug Use and Return to Treatment: National Followup Study of Admissions to Drug Abuse Treatment in the DARP During 1969-1971
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Investigation of Rural Drug Abuse Programs
The Learning Laboratory - The Door - A Center of Alternatives
Leisure Patterns of Opioid Addicts: A Six Year Follow-Up of Clients
Linking Drug Abuse Treatment Programs with CETA
Management Information Systems in the Drug Field
A Manual on Third-Party Reimbursement Strategy for States and Communities
Marihuana and Health 1976
Marijuana and Health 1980
Marijuana and Health 1980 (Spanish)
Marijuana Testimony-By William Pollin, M.D., before the Subcommittee on Criminal Justice Committee on the Judiciary, United States Senate, Juanary 16, 1980
Medical Evaluation of Long-Term Methadone Maintained Clients
Medical Treatment for Complication of Polydrug Use
Methadone Diversion: Experiences and Issues
Monitoring Drug Use in the Community Through a Jail Urine Screening Program
NIDA Research on Drug Abuse: Division of Research Monograph Series July 1980
National Drug/Alcohol Collaborative Project: Issues in Multiple Substance Abuse
National Drug Abuse Treatment Utilization Survey (NDATUS)
National Manpower and Training System Source Book October 1979/October 1980
National Survey on Drug Abuse: Main Findings 1979
Nonurban Drug Abuse Program: A Descriptive Study
Nurse Practitioners and Physician Assistants in Substance Abuse Programs

PCP: A Review
Phencyclidine Use Among Youth in Drug Abuse Treatment
The Problem-Drinking Addict
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Psychosocial Characteristics of Drug-Abusing Women
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Second Annual Report - Drug Abuse Prevention, Treatment and Rehabilitation
Securing Employment for Ex-Drug Abusers
Sedative-Hypnotic Drugs: Risks and Benefits
Services Research Branch Notes March 1978
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Skills Training and Employment for the Ex-Addicts in Washington, D.C. - A Report on TREAT
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The Use of Volunteers in Drug Abuse Services: A Review of the Literature
Utilization of Third-Party Payments for the Financing of Drug Abuse Treatment
Treatment Research Notes March 1981
Vanguards in Training
Withdrawal from Methadone Maintenance: Rate of Withdrawal and Expectations
Women and Drug Abuse Treatment: Needs and Services

BOOKS - GENERAL:

Juvenile Deliquency: Perspectives, Programs, Problems, and Solutions

Lexington Books
D.C. Heath & Co.
125 Spring Street
Lexington, MA 02173

A. "99 films on Drugs"
38 page booklet (free)

gives teenager & adult evaluations
of 99 drug education films

University of California
Extension Media Center
Berkeley, CA 94720

B. 100 Ways to Enhance Self-Concept in The Classroom

Canfield, J. & Wells, H.C.
Prentice - Hall Inc.
Englewood Cliff, NY 07632

(contains over 100 classroom tested techniques, K-college designed to enhance self-esteem and one's sense of identity. The techniques are classified under 7 major topic areas including: building a supportive environment, individual strengths, personal identity, accepting one - self, developing goals, self-description, and relationships with others. In addition, an annotated bibilography is included).

Parenting
by G. Ron Norton

Prentice Hall Inc.
Englewood Clifts, NJ 07632

(For parents, teachers, and others who care for children. With the guide to helping children grow, you can choose from a variety of step by step techniques to handle individual learning situations).

Parents Handbook - A part of the Complete Program
Systematic Training for Effective Parenting
by Don Dinkmeyer and Gary D. McKay

American Guidance Service, Inc.
Circle Pines, MN 55014

Strengthening the Family (NEW)
by H. Stephen Glenn
Cost $1.50

Potomac Press
Pacific Institute for Research & Evaluation
7101 Wisconsin Ave, Suite 1006
Bethesda, MD 20014

Techniques of Attitude Scale Construction
by Allen E. Edwards

Appleton-Century-Croft Inc.
New York, NY

T.E.T. - Teacher Effectiveness Training

T. Gordon and Peter H. Wyden
New York, NY

(This book focuses on the teacher-student relationship presenting the principles and skills necessary to understand and use T.E.T. in the classroom. K-College-Retarded-Gifted). A guide to the parent-teacher-student relationship is included as an aid in evaluating and communicating with teachers. Communication and listening skills are emphasized throughout the text, dealing with issues such as: Teacher-student relationships, disciplinary problems, advising and counseling, resolving conflict, teacher values, and teacher-administration relationships.

You Are Somebody Special
by Bill Cosby Charlie W. Shedd
Rich Little Irene Kassorla
Jim Fadiman Jim Dobson
Eugene Nidu Carl Hall
Richard Bolles and Myrtle T. Collins

McGraw Hill Book Company
New York, NY

FILMS

Drug Abuse Films:

National Coordinating Council on Drug Education
Suite 212, 1211 Conn. Ave. N.W.
Washington, D.C. 20036

Drug Abuse Self-Awareness for Teachers

Videotapes available from BOCES and
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NEWSLETTERS:

Request these printed materials and details of membership in order to receive their newsletters with continually updated information.

The American Council on Marijuana and Other Psychoactive Drugs Inc.
New York, NY 10022
(212-758-8060)
Attention: Robert L. DuPont, President

Phoenix House Foundation, Inc.
164 West 74th Street
New York, NY 10023
(212-595-5810)
Attention: Dr. Mitchell Rosenthal, President

National Institute on Drug Abuse (N.I.D.A.)
5600 Fishers Lane
Rockville, MD 20857
(202-655-4000)

Pyramid - Prevention Branch
Division of Resource Development
N.I.D.A.
7101 Wisconsin Ave, Suite 10016
Bethesda, MD 10014
(301-654-1194)

PERIODICALS:

Listen - A Journal of Better Living (provides scientific education for the prevention of drug addiction and alcoholism).

Narcotics Education Inc.
6830 Laurel St. N.W.
Washington, D.C. 20012

Smoke Signals - Eight page monthly minature newspaper format to interpret the extensive tobacco research of today and encourage healthful living in the light of these findings.

Narcotics Education Inc.
6830 Laurel St. N.W.
Washington, D.C. 20012

Alcohol Health & Research World Quarterly of N.I.A.A.A.
Assistant Public Printer

Superintendent of Documents
Government Printing Office
Washington, D.C. 20402

Alive & Well - Free copy

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Waco, TX 76710

Citizens for Informed Choices on Marijuana
300 Broad Street
Stamford, CT 06901

(A one-year membership, including series of four booklets, "How to Help Your Child Resist the Marijuana Culture", plus bi-monthly newsletter). $10.00

Committees of Correspondence
P.O. Box 1590
Cathedral Station
New York, NY 10025

(Information on one important drug abuse issue each month, plus suggestions on how correspondents can most effectively communicate their concerns on each issue and thus influence the outcome). $5.00 /year

"Family Health Magazine"

A.M.A.
535 North Dearborn Street
Chicago, IL 60610

The Smoking Digest - Progress Report on a Nation Kicking the Habit

U.S. Dept. of Health, Education & Welfare
Public Health Service
National Institute of Health
National Cancer Institute
Bethesda, MD 20014

ALCOHOL ABUSE INFORMATION CENTERS

Alcoholics Anonymous
P.O. Box 459
Grand Central Station
New York, NY 10017

National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, MD 20852

(Distributes alcohol related pamphlets, books, posters, and other materials published by National Institute on Alcohol Abuse & Alcoholism)
"Publications Order Form"
"Current Awareness Services"

The National Council on Alcoholism, Inc.
733 Third Avenue
New York, NY 10017

CATALOGS & PUBLICATIONS:

Annotated Resource Guide Abuse/Misuse
Prevention Education Programs
Secondary Level

Bureau of Drug Education
N.Y.S. Education Dept.
9th Floor EBA
Albany, NY 12234
Elementary Level (1978)

Comp Care Publications
(Quality Books & Materials With a Positive Approach to Life's Problems)

A Division of Comprehensive Care Corporation
Department 337
P.O. Box 27777
Minneapolis, MN 55427

Hazelden - 1981 Catalog
(Books, audiovisuals, consulting services)

Call 800-328-9288
Box 176
Center City, MN 55012

Health Instructional Resource Center
(Subject listing for HIRC holdings)

Cortland-Madison BOCES
McEvoy Educational Center
Cortland, NY 13045

Smoking Hazards: Educational Material available in N.Y.S.

N.Y.S. Interagency Committee on Hazards of Smoking
31st Floor
Alfred E. Smith State Office Building
Albany, NY 12225

Teachers Guide to The Coronado Plan for Prevention/Drug Abuse Education
Coronado Unified School District
Coronado, CA

Value Education Publications
P.O. Box 947
Cambell, CA 95008

Secondary Grades 7-8
9-12

The Help They Need
(A Narcotic Education Catalog)

Narcotics Education Inc.
P.O. Box 4390
Washington, D.C. 20010
(202-723-4774)

Where The Drug films are: A Guide to Evaluation, Services & Distributors

National Institute on Drug Abuse
D.H.E.W. Publication No. (ADM) 77-429
Printed 1977

Educational Activities Inc.
Freeport, NY 11520

Materials From: American Lung Association
of Central New York, Inc.
2013 E. Genesee Street
Syracuse, NY 13201

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BATTLE TO BREATHE - COLOR, 25 MINUTES

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BREATHING EASY - COLOR, 27 1/2 MINUTES

THROUGH THE USE OF THE U.S. SPACE COMPUTER CENTER, A YOUNGSTER FANTASIES HIMSELF INTO THE BRAIN AND THE HUMAN RESPIRATORY SYSTEM AND DISCOVERS HOW IT WORKS. THE EXPERIENCE HAS PARTICULAR APPLICATION TO SMOKING AND AIR POLLUTION, AND ALSO DEALS WITH THE WHOLE CONCEPT OF THE HEART AND BLOOD SYSTEMS. WHILE MADE FOR 5TH TO 8TH GRADERS, IT HAS AN INTEREST FOR AN AUDIENCE OF ALL AGES.

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EMPHYSEMA - THE FACTS - COLOR, 15 MINUTES

POWERFUL DOCUMENTARY REPORT ON CAUSES, EFFECTS, TREATMENT AND PREVENTION OF THIS DISEASE. OFFERS CONVINCING ANTI-SMOKING ARGUMENT FILMED IN A HOSPITAL. FOR PATIENTS, ADULT MEETINGS, CIVIC AND COMMUNITY GROUPS. EQUALLY VALUABLE FOR HIGH SCHOOL AND COLLEGE HEALTH EDUCATION COURSES.

ENEMY IN LINCOLNBORO

THIS FILM DEALS WITH THE EFFECTS OF AIR POLLUTION (PRINCIPALLY SULPHUR DIOXIDE, SO_2 IN THIS CASE) ON PEOPLE AND THINGS IN AND AROUND A SUBURB OF PITTSBURGH, PENNSYLVANIA. THE FILM IS VERY GRAPHIC, SOMEWHAT FRIGHTENING, BUT IS NOT EXAGGERATED FOR THAT AREA. BEST FOR 7TH GRADE AND UP. NEEDS EXPLANATION AND DEFINITION FOR YOUNGER CHILDREN.

EVERYTHING YOU ALWAYS WANTED TO KNOW ABOUT HOW TO STOP SMOKERS BUT WERE AFRAID TO TRY - COLOR, 8 MINUTES

UNREHEARSED INTERVIEWS WITH NONSMOKERS, FILLED WITH HUMOR AND IMAGINATION - A NONSMOKER'S BILL OF RIGHTS. FOR YOUNG AND OLD ALIKE.

LIFE AND BREATH - COLOR, 15 MINUTES

DEVELOPMENT AND TREATMENT OF EMPHYSEMA IN ONE MAN. INCORPORATES TECHNIQUE OF DETECTION, EXAMINATION AND TREATMENT WHILE AT THE SAME TIME DRAWING VERY SPECIFIC ATTENTION TO THE ROLE OF CIGARETTE SMOKING AS A CONTRIBUTING FACTOR TO THE DISEASE DEVELOPMENT. FOR YOUNG, MATURE AUDIENCES WHERE THE SMOKING FACTOR IS IMPORTANT AND FOR GENERAL AUDIENCES OF LAYMEN.

OCTOPUFF IN KUMQUAT - COLOR, 9 MINUTES

A CHARMING ANTI-SMOKING FABLE IN WHICH AN INVADING OCTOPUFF CHARACTER TEACHES A TOWN TO SMOKE AND THEN, IN TURN, IS CONVERTED BY THE CHILDREN TO BECOME A NON-SMOKER. IT IS AN INVALUABLE PRESENTATION FOR THE PRE-SCHOOL AND K 1-3 CHILDREN AND A SUBTLE WAY TO EDUCATE UP TO EVEN THE 8 YEAR OLDS, BUT WILL DELIGHT ANY AUDIENCE.

POINT OF VIEW - BLACK/WHITE, 19 MINUTES

OFFBEAT COMMENT ON CIGARETTE SMOKING THAT POINTS UP THE USE OF CIGARETTES AS BOTH FOOLISH AND DEADLY. ENCOURAGES YOUNG PEOPLE TO QUESTION THEIR OWN FEELING - AND BEHAVIOR - ABOUT SMOKING. DESIGNED FOR TEENAGERS, PARTICULARLY OF HIGH SCHOOL AND COLLEGE AGE, BUT ALSO FOR YOUTH AND PARENT ORGANIZATIONS AND COMMUNITY GROUPS.

ROX, SOX, NOX - THE ANATOMY OF AIR POLLUTION - COLOR, 12 1/4 MINUTES

A HARD-HITTING AND EFFECTIVE TEACHING TOOL, THIS FILM CLEARLY DEFINES AND DEMONSTRATES THE CAUSE AND EFFECT OF AIR POLLUTION. TEST-TUBE DEMONSTRATIONS SHOW DRAMATICALLY THE COMPLEX CAUSE/EFFECT RELATIONSHIPS INVOLVED IN AIR POLLUTION - DONE BY DR. JAMES PITTS, ONE OF THE FOREMOST EXPERTS ON AIR POLLUTION. HE ALSO EXPLAINS THE HEALTH ASSAULT AND SOCIO-ECONOMIC FACTORS INVOLVED IN THE BATTLE AGAINST AIR POLLUTION. FOR HIGH SCHOOL, COLLEGE SCIENCE AND HEALTH COURSES - ALSO COMMUNITY GROUPS CONCERNED WITH AIR CONSERVATION AND ECOLOGY.

SPIROMETRY - COLOR, 24 MINUTES

SUPPORTS ADDING PULMONARY FUNCTION TESTS TO EXAMINATIONS TO DIAGNOSE AND TREAT CHRONIC BRONCHITIS AND EMPHYSEMA EARLY. FOR PHYSICIANS.

THE SPECIAL UNIVERSE OF WALTER KROLIK - COLOR, 24 MINUTES

DESIGNED FOR THE EDUCATION OF RN'S AND PHN'S IN-TRAINING AND IN-SERVICE. SHOULD BE SHOWN ONLY WITH NURSE DISCUSSION LEADER. NOT SUITABLE FOR SHOWING TO GENERAL PUBLIC. MOVING DRAMA OF A FAMILY MAN WHO DISCOVERS HE HAS TUBERCULOSIS. EXAMINES THE COMPLEX RELATIONSHIPS BETWEEN PATIENT AND MEDICAL AND PARAMEDICAL STAFF, WITH SPECIAL EMPHASIS ON NURSES. TRAINING FILM FOR NURSES.

AMERICAN LUNG ASSOCIATION OF CENTRAL NEW YORK

EDUCATIONAL AIDS

HUMAN LUNGS - TWO (PRESERVED IN GLASS) HUMAN LUNGS, SHOWING THE DIFFERENCE BETWEEN NORMAL AND CANCEROUS. ALL AGES.

CHEMICALS BOARD - DISPLAY OF SIMULATED CHEMICALS FOUND IN TOBACCO SMOKE. ALL AGES.

AMERICAN LUNG ASSOCIATION OF CENTRAL NEW YORK DISPLAY - GENERAL INFORMATION ABOUT THE SERVICES AND FUNCTIONS OF THE AMERICAN LUNG ASSOCIATION OF CENTRAL NEW YORK.

AIR POLLUTION FELT BOARD - COMPLETE WITH TEACHER'S GUIDE FOR LESSONS, THIS FELT BOARD ADAPTS TO EASILY ALLOW STUDENTS TO USE IT. SEVERAL LESSONS INCLUDED IN GUIDE, AND GOOD BACKGROUND INFORMATION.

SMOKING LUNGS - TWO, WHITE, PLASTIC-COVERED SPONGES RESEMBLE THE LUNGS. USE A LIGHTED CIGARETTE, SQUEEZE, AND THEY "SMOKE". SPONGES DISCOLOR FROM THE EFFECT OF ONE CIGARETTE, AND MORE WITH REPEATED USE. GOOD VISUAL EFFECT AND EXCELLENT FOR DEMONSTRATING HOW SMOKING LEAVES RESIDEUS IN LUNGS. ALL AGES.

BIOFEEDBACK SMOKING EDUCATION PROGRAM - THIS PROGRAM EMPHASIZES SMOKING'S IMMEDIATE EFFECTS ON THE BODY. USING A CARBOXIMETER TO MEASURE THE AMOUNT OF CARBON MONOXIDE IN THE BREATH, A DIGITAL HEART RATE MONITOR TO MEASURE PULSE RATE, A DIGITAL THERMOMETER TO MEASURE SKIN TEMPERATURE, AND A HOMEMADE "TREMOR TESTER", STUDENTS CAN SEE FIRSTHAND HOW CIGARETTES IMPAIR MANUAL CONTROL, INCREASE PULSE RATE, LOWER SKIN TEMPERATURE, AND INCREASE CARBON MONOXIDE IN THE BREATH.

THE EQUIPMENT IS DELIVERED TO A SCHOOL BY A STAFF MEMBER OF THE LUNG ASSOCIATION. APPROXIMATELY 2 HOURS ARE SPENT TRAINING THE SCIENCE TEACHER TO USE THE EQUIPMENT AND PROVIDING INFORMATION ON SMOKING.

THE FOLLOWING WEEK, STUDENTS SPEND 50 MINUTES EACH DAY IN AN APPROPRIATE SCIENCE CLASS DISCUSSING THE SCIENTIFIC METHOD AS THE BASIS FOR THE WEEK'S EXPERIMENTS, REVIEWING THE LONG AND SHORT TERM EFFECTS OF SMOKING AND USING THE EQUIPMENT. DATA ARE COLLECTED ON SMOKERS BEFORE AND AFTER SMOKING A CIGARETTE (PARENTAL PERMISSION IS REQUIRED). NONSMOKERS ARE ALSO TESTED TWICE, SERVING AS CONTROLS. IN THE FINAL PERIOD OF THE WEEK STUDENTS PRESENT THE DATA, DRAW CONCLUSIONS, AND RELATE FINDINGS TO GENERAL HEALTH CONSIDERATIONS. THE TEACHER PROVIDES ADDITIONAL INFORMATION ON PHYSIOLOGY AND SMOKING.
(GRADES 7-12 - AND - COLLEGE)

TELEPHONE: AREA CODE 315 - 422-6142

ALA/CNY 2-81

Materials from: American Cancer Society
25 Clinton Avenue
Cortland, NY 13045

National Headquarters
777 3rd Ave
New York, NY 10017

BOOKS & PAMPHLETS

1. Huff "n" Puff
2. The Story of a Cigarette (Coloring Book)
3. Taking a chance with no chance at all (Coloring Booklet)
4. Why start a life under a cloud
5. To smoke or not to smoke
6. The Decision is Yours
7. The Great Imitators
8. Quit Cigarettes/Live Longer
9. Quitters Guide - 7 day Plan to Help You Stop Smoking Cigarettes
10. I'll Choose the High Road - by not starting to smoke
11. Danger Cigarettes
12. About Cigarette Smoking & Lung Cancer/ Answering the most often asked questions
13. Helping Smokers Quit - Smoking Withdrawal Project
14. So You Want to Stop? You Can!

AUDIOVISUALS

1. Cigarette Smoking: Take it or leave it (filmstrip)
2. An Early start to good Health (Kit)
3. Smoking Past & Present (film)
4. Take Joy (film)
5. Decision for Mike (film)
6. Posters for Youth
7. The Huffless, Puffless Dragon (film)
8. Cigarette Smoking - Take it or leave it (filmstrip)

STICKERS/BUTTONS/BOOKMARKS

1. I Quit - Great American Smokeout
2. Kiss me I don't Smoke (one is Lips and one if Frog)
3. Quit Smoking
4. Hello - I Stopped Smoking
5. I Quit
6. Do It - Stop Smoking
7. Cancer Won't Wait - Educate
8. Puff Off
9. Eat an Apple - Don't Smoke
10. I Smoked One less Cigarette Today
11. Thank You for Not Smoking (Desk sign too)
12. Kissing a Smoker is Like Licking an Ashtray
13. Best Tip Yet: Don't Smoke (Bookmark)

Materials From: American Heart Association
40 Main Street
Cortland, NY 13045

BOOKS & PAMPHLETS

1. Cigarette Quiz
2. What Everyone Should Know About Smoking & Heart Disease
3. The American Heart Association Has Something Important to Say

AV MATERIALS

1. Barney Butt
2. Smoking & Heart Disease

Materials From: American Medical Association
535 North Dearborn Street
Chicago, IL 60610

BOOKS & PAMPHLETS

1. Glue Sniffing - OP195
2. The Crutch That Cripples - OP163
3. Amphetamines - OP197
4. Barbiturates - OP196
5. LSD - OP194
6. Marijuana - OP198

The following sources are considered to be misleading and false in a significant number of their statements:

1. NORML - (National Organization for the Reform of Marijuana Laws)

2. Do It Now Foundation

Institute for Chemical Survival
Phoenix, Arizona

CONTACT AGENCIES
FOR
RESOURCES

For Technical Assistance:

Project Pyramid
3746 Mt. Diablo Blvd.
Lafeyette, CA 94549
1-800-227-0438 Toll Free

State Authority/State Prevention Coord.
DRACON (Large quantities)

Ask them to send list of 5th grade programs that work. Tell them of organizational problems that you may be encountering.

For Materials:

NIDA Resource Center
Parklawn Bldg.
Room 10A-54
Rockville, MD 20859
1-202-443-6614

National Center on Alcohol Education
1601 N. Kent Street
Arlington, VA 22209
1-703-527-5757

National Federation of Parents for Drug Free Youth
9805 Dameron Drive
Silver Springs, MD 20902

Quest, Inc.
2703 N. Main Street
Findlay, OH 45840
1-419-424-9693

National Clearinghouse on Drug
Abuse Information (NCDAI)
Parklawn Bldg.
P.O. Box 1909
Rockville, MD 20850
1-202-443-6500

RESOURCES

FOR

PARENTS

SMOKING - PAMPHLETS:

The Suprising News About Women and Smoking

U.S. Dept. of H.E.W.
Public Health Services
Center for Disease Control
Bureau of Health Education
National Clearinghouse for Smoking & Health
D.H.E.W. Publication No. (CDC) 75-8733

See pamphlet listing under Teachers and Administrators Section

ALCOHOL - PAMPHLETS:

Al-Anon: Family Treatment Tool in Alcoholism

Write to: Al-Anon Family Group Headquarters
P.O. Box 182
Madison Square Station
New York, NY 10010

Alcohol Some Questions & Answers

National Institute on Alcohol Abuse & Alcoholism
5600 Fishers Lane
Rockville, MD 20852

Publication No. (HSM) 71-9048

Alcoholism

Write to: Blue Cross/Blue Shield Association
840 North Lake Shore Drive
Chicago, IL 60611

Alcoholism A Merry-go-round Named Denial
by Joseph L. Kellerman

Hazelden Educational Services
Box 176
Center City, MN 55012

Alcoholism & The Family
by Donald E. Meek , D.S.W.

Write to: Alcoholism & Drug Addiction Research Foundation
Toronto, Canada

Drinking Etiquette

Alcohol, Drug Abuse & Mental Health Admin.
National Institute on Alcohol Abuse & Alcoholism
5600 Fisher Lane
Rockville, MD 20852

Guide For The Family of the Alcoholic
Public Relations (D-1)

Kemper Insurance Companies
Long Grove, IL 60049

Here's Looking At You: The Drinking American
DHEW Publication No. (ADM) 76-348

National Institute on Alcohol Abuse & Alcoholism
5600 Fishers Lane
Rockville, MD 20852

The Illness called Alcoholism

American Medical Association
535 North Dearborn Street
Chicago, IL 60610

13 Steps to Alcoholism

National Council on Alcoholism
N.Y. Academy of Medicine Building
2 East 103rd Street
New York, NY

What Everyone Should Know About Alcoholism

Channing L. Bete Co. Inc.
Greenfield, MA 01301

ALCOHOL - BOOKS:

Alcoholism - A Family Illness
by Betty Reddy

Lutheran Center for Substance Abuse
Lutheran Alcoholism Treatment
1700 Luther Lane
Park Ridge, IL 60068

"I'll Quit Tomorrow"
by Vernon Johnson
Cost $10.95 (182 pages)

Hazelden Educational Services
Box 176
Center City, MN 55012

Topical Storms

Alcoholism: A Definition

Alcoholism is a chronic, progressive, and potentially fatal disease. It is characterized by tolerance and physical dependency or pathologic organ changes, or both — all the direct or indirect consequences of the alcohol ingested.

1. "Chronic and progressive" means that the physical, emotional, and social changes that develop are cumulative and progress as drinking continues.

2. "Tolerance" means brain adaptation to the presence of high concentrations of alcohol.

3. "Physical dependency" means that withdrawal symptoms occur from decreasing or ceasing consumption of alcohol.

4. The person with alcoholism cannot consistently predict on any drinking occasion the duration of the episode or the quantity that will be consumed.

5. Pathologic organ changes can be found in almost any organ, but most often involve the liver, brain, peripheral nervous system and the gastrointestinal tract.

6. The drinking pattern is generally continuous but may be intermittent, with periods of abstinence between drinking episodes.

7. The social, emotional, and behavioral symptoms and consequences of alcoholism result from the effect of alcohol on the function of the brain. The degree to which these symptoms and signs are considered deviant will depend upon the cultural norms of the society or group in which the person lives.

National Council on Alcoholism/American Medical Society on Alcoholism Committee on Definition. Reprinted with permission from Annals of Internal Medicine *85:764, 1979.*

Fetal Alcohol Syndrome

by Christine M. Olson

HEAVY DRINKING

Does alcohol abuse have any effect on a pregnant woman or her baby? At least two million alcoholics are women, and one half of these are of childbearing age (1). The National Institute on Alcohol Abuse and Alcoholism estimates that each year at least 1,500 babies, one in every 2,000, are born with the full-blown effects of Fetal Alcohol Syndrome (2).

What is Fetal Alcohol Syndrome? In 1972 Dr. Christy N. Ulleland described a group of six infants born to chronic alcoholic mothers at Seattle's Harborview Medical Center. The infants were born underweight for gestational age and were abnormally slow in postnatal growth and development (3).

The most extensive research to describe this syndrome has been conducted at the University of Washington in Seattle by Dr. Kenneth L. Jones and his colleagues, including Dr. Ulleland. Their initial studies, published in 1973, described 11 unrelated children of different ethnic backgrounds, all of whom were born to chronic alcoholic women (4, 5, 6).

Prenatal and postnatal growth deficiency occurred in all 11 children. Prenatal growth deficiency in length was more severe than in weight — in direct contrast to most studies of generalized maternal undernutrition in which newborn infants are underweight for their age. The prenatal growth deficiency persisted throughout the first year of life in each of the nine children who were followed that long. Growth in length was 65 percent of normal and weight gain was 30 percent of normal despite the fact that six of the children were known to have adequate caloric intakes at intervals throughout the year and that three were receiving excellent foster care.

Microcephaly, or small head size, was common. Head circumference was less than the third percentile for chronological age in 10 out of 11 infants both at birth and at age one.

All of the children showed developmental delay or mental deficiency. Intelligence quotients ranged from below 50 to 82, with a mean of 63. (Average IQ is about 100.) Most of the children had both fine and gross motor dysfunction.

Abnormality in craniofacial features was evident in most of the children. Short eye slits were the most common. They were thought to be secondary to decreased eye growth.

Joint anomalies were present in a number of the children, although they varied. Some of the children were born with a dislocated hip. Others could not extend their elbows completely. Also, 70 percent had some type of cardiovascular anomaly.

Two subsequent studies carried out by the Seattle group have confirmed these findings. In the first, the medical records of 23 chronic alcoholic women and their infants in the nationwide Collaborative Perinatal Project were studied. Forty-three percent of the women had what was called an adverse outcome of pregnancy, meaning that their infants had died or had been born with Fetal Alcohol Syndrome. Four of the babies died in utero or within one week of age — a perinatal mortality rate of 17 percent. In the survivors, borderline to moderate mental deficiency was the most common problem, occurring in 44 percent of the children. Thirty-two percent had sufficient abnormal features to suggest Fetal Alcohol Syndrome (7).

In the second study, 41 patients

more

Adapted from the October 1977 DNS Professional Perspectives: Food and Nutrition Issues. *The author is an assistant professor in the Division of Nutritional Sciences, New York State College of Human Ecology and New York State College of Agriculture and Life Sciences, Cornell University.*

were evaluated. The pattern of defects appeared again (8).

The mechanism of the effect on the developing fetus is not known. The alcohol itself may be directly toxic to the fetus. Alcohol freely crosses the placenta and is distributed in the water phase of the fetal tissues. Alcohol has been recovered from fetal blood in approximately the same concentration as in the mother's. Alcohol has been detected on the breath of newborn babies and in the amniotic fluid. It is also possible that the breakdown products of alcohol such as acetaldehyde and other substances in alcohol are the direct toxins (6). The symptoms seen in humans and animals (9) do not support the notion that the Fetal Alcohol Syndrome is a consequence of undernutrition secondary to alcoholism.

Recent research indicates that some pregnant women may have a "built-in" mechanism which helps protect their babies from excess amounts of toxic substances (10). A sample of 162 white, middle-class, pregnant women belonging to a health maintenance organization were interviewed about their dietary, smoking and drinking habits. The interviews produced estimates of alcohol consumption during the six months before pregnancy, the first four months of pregnancy and the second four months of pregnancy. Before pregnancy, seven percent of the women were consuming more than one ounce of absolute (100 percent or 200 proof) alcohol daily and 18 percent were consuming between one-half and one ounce. In early pregnancy, these figures dropped to two and six percent. Overall, two-thirds of the women drank less during early pregnancy than before pregnancy. The major reasons given (especially by the heavier drinkers) were related to some adverse physical effect produced by alcohol: nausea, stomach irritation, or alcohol's bad smell, taste or diuretic effect. Other considerations were fetal welfare and health.

MODERATE DRINKING

Dr. Ernest P. Noble, Director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has said, "Both the risk and the extent of abnormalities appear to be dose-related, increasing with higher alcohol intake during the pregnancy period." While safe levels of drinking are not known, Dr. Noble notes that a risk appears at three ounces of absolute alcohol, or six or seven mixed drinks, per day. Between one and three ounces, there is still uncertainty, but caution is advised (2). Consequently, NIAAA is advising one ounce (two or fewer drinks) as a guideline.

In April 1977, Dr. James W. Hanson reported the results of a study of 163 infants (11, 12). Eighty-two infants were considered at risk because their mothers consumed at least one ounce of absolute alcohol a day either during the month before they knew they were pregnant or during the first five months of pregnancy. Eighty-one were controls whose mothers drank less. Dr. Hanson examined the infants without knowledge of maternal drinking history and rated them on four indicators of Fetal Alcohol Syndrome: size for gestational age, microcephaly, short eye slits and other abnormalities in physical features. Eleven of the 163 had features compatible with Fetal Alcohol Syndrome. Nine were from the group whose mothers consumed more than one ounce of alcohol and two were from the control group. Two of the nine infants had full-blown Fetal Alcohol Syndrome, and their mothers were the heaviest drinkers in the experimental group. Dr. Hanson says that the association between maternal drinking in the period immediately before pregnancy was clear, and he is concerned that a woman may not cut down on her drinking soon enough. He suggests that women should stop or cut down on drinking as soon as they plan to become pregnant.

Research from the Boston City Hospital Prenatal Clinic shows that most pregnant women want to reduce heavy drinking when potential hazards are explained and education and supportive psychotherapy are provided.

In light of the "natural" tendency of some women to decrease alcohol consumption during pregnancy and the results of various intervention programs, an optimistic attitude seems appropriate.

However, the largest challenge facing health and education professionals may well be working with teenage mothers who, like other members of society, are abusing alcohol. ◻

REFERENCES

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(2) Drinking during pregnancy. *Children Today* 6:28, 1977.

(3) Ulleland, C. N. The offspring of alcoholic mothers. *Annals of the New York Academy of Sciences* 197:167, 1972.

(4) Jones, K. L., D. W. Smith, D. N. Ulleland, and A. P. Streissguth. Pattern of malformation in offspring of chronic alcoholic mothers. *Lancet* 1:1267, 1973.

(5) Jones, K. L. and D. W. Smith. Recognition of the fetal alcohol syndrome in early infancy. *Lancet* II:999, 1973.

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(7) Jones, K. L., D. W. Smith, A. P. Streissguth, and N. C. Myrianthopoulos. Outcome in offspring of chronic alcoholic women. *Lancet* 1:1076, 1974.

(8) Hanson, J. W., K. L. Jones, and D. W. Smith. Fetal alcohol syndrome: Experience with 41 patients. *Journal of the American Medical Association* 235:1458, 1976.

(9) Tze, W. J. and M. Lee. Adverse effects of maternal alcohol consumption on pregnancy and foetal growth in rats. *Nature* 257:479, 1975.

(10) Little, R. E., F. A. Schultz, and W. Mandell. Drinking during pregnancy. *Journal of Studies on Alcohol* 37:375, 1976.

(11) Hanson, J. W., A. P. Streissguth, and D. W. Smith. The effects of moderate alcohol consumption during pregnancy on fetal growth and morphogenesis. Paper presented at the annual meetings of the American Pediatric Society and the Society for Pediatric Research. April 1977.

(12) Even moderate drinking may be hazardous to maturing fetus. *Journal of the American Medical Association* 237:2585, 1977.

DRUGS - Pamphlets :

Drug Abuse Prevention (For Your Family)
DHHS - Publication No. (ADM) 81-584

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, MD 20857

For Parents Only: What You Need to Know About Marijuana

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, MD 20857

(Contains the latest scientific information in a fast reading question & answer format. It covers everything from marijuana's effects on health to ideas on what parents can do.)

(Free - as many copies as needed)

Homer Drug & Alcohol Awareness Week 1980
by the Homer Parents Group
Phyllis Wainman & Judy Szynalak - Co-Chairpersons
Homer, NY 13077

Parents & Problems - through the Eyes of Youth
by Fred Streit Ed. D.
168 Woodbridge Ave
Highland Park, NJ 08904
(201-572-3120)

DRUGS - BOOKS :

Drug Abuse from the Family Perspective

Dept. Health & Human Services
Alcohol & Drug Abuse & Mental Health Adm.
5600 Fisher Lane
Rockville, MD 20857

Drug & Alcohol Abuse - Implications for Treatment

National Institute on Drug Abuse
5600 Fishers Lane
Rockville, MD 20857

How To Get Your Child off Marijuana
by Harold Voth, M.D. 1980 (24 pages)
Cost $2.95

Patient Care Publications Inc.
Distributed by: Citizens for Informed Choices on Marijuana Inc.
300 Broad Street
Stamford, CT 06901

How to Talk to Kids About Drugs
by Suzanne Fornaciasi

Potomac Press
Pacific Institute for Research & Evaluation
7101 Wisconsin Ave, Suite 1006
Bethesda, MD 20014

Marijuana Today - A Compliation of Medical Findings for the Layman
by George K. Russell
Cost $3.00 (86 pages)

The Myrin Institute for Adult Education
521 Park Ave
New York, NY 10021

Marijuana: Updated Reading Selected for Families and Others
Concerned About Youth
compiled by Carolyn Quarles, 1980

An integrated and indexed notebook of resources materials. Summarizes recent research, lists, agencies recommends books, names professionals and includes texts of their conference papers,reports or parent groups. Cost $12.00 (230 pages)

Order from: Hampshire Informed Parents Inc.
24 South Sunset Ave
Amherst, MA 01002

Parents, Peers & Pot
by Marsha Manalt Ph.D.
98 pages (N.I.D.A.) Single Copies free

National Clearinghouse for Drug Abuse Information
5600 Fishers Lane
Rockville, MD 20857

DRUGS - FILM:

For Parents Only: What Kids Think About Marijuana
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NEWSLETTERS - Request these printed materials and details of membership in order to receive their newsletters with continually updated information.

Families in Action
Sue Rushe, President
P.O. Box 15053
Atlanta, Georgia 30333
(404-378-3310)

N.F.P. (National Federation of Parents)
Box 57217
Washington, D.C. 20037

Pride - (Parent Resources & Information on Drug Education)
Dr. Thomas Gleaton, Director

Georgia State University
University Plaza
Atlanta, Georgia
(404-658-3548)

Public Affairs Pamphlets
(Aids for Family Life Counseling & Education)
381 Park Ave. South
New York, NY 10016
(212-683-4331)

PERIODICALS:

Families in Action
1436 Cornell Rd. N.E.
Atlanta, GA 30306

(164 page manual on how organize your community to combat the "kiddie drug culture", including drug paraphernalia. $10.00. Plus quarterly newsletter which includes latest information on the drug scene at state, national and international levels. $3.00)

Listen - A Journal of Better Living

Narcotics Education Inc.
6830 Laurel St. N.W.
Washington, D.C. 20012

(Provides scientific education for the prevention of drug addiction and alcoholism)

The Smoking Digest - Progress Report on a Nation Kicking the Habit

Public Health Service
National Institute of Health
National Cancer Institute
Bethesda, MD 20014

The Winner

Magazine helps guide elementary school aged children into a lifestyle free from destructive dependence.

Narcotic Education Service
6830 Laurel St. N.W.
Washington, D.C. 20012

BOOKS - GENERAL:

Coping With Children's Misbehavior: A Parents Guide
by Rudolf Driekurs, M.D. Cost $3.50

1. Learn why your child misbehaves and what you can do about it.
2. Find new,more effective methods of child discipline.
3. Discover modern and efficient solutions to trying situations, including temper tantrums, poor performance in school, and many others.

Dare to Discipline
by Dr. James Dobson

Bantam Books Inc.
Dept. BB
414 East Gulf Road
Des Plains, IL 60616

(Permissiveness doesn't work. Nowa famous child psychologist shows how firm control is the key to real love)

Helping Your Child Learn Right From Wrong:
A Guide to Values Clarification
by Dr. Sidney B. Simon & Sally Wendkos Olds
Cost $2.95

McGraw Hill Book Co.
New York, NY

High of Life
by Lee Silverstein

(Story of alcohol addiction & recovery)

Health Communications Inc.
2119-A Hollywood Blvd.
Hollywood, FL 33020

How to Form A Families in Action Group in Your Community
by Sue Rusche 1979 164 pages
Cost $10.00

Families in Action
P.O. Box 15053
Atlanta, Georgia 30333

No Substitute For Love - Ideas for Family Living

Hazelden
Box 176
Center City, MN 55012

Parenting
by G. Ron Norton
Cost $3.95

For Parents, teachers, and others who care for children. With this guide to helping children grow, you can choose from a variety of step by step techniques to handle individual learning situations.

Prentice Hall Inc.
Englewood Cliffs, NY 07632

604

Parents Handbook
by Don Dinkmeyer and Gary D. McKay

A part of the complete program of Systematic
Training for Effective Parenting.

American Guidance Service, Inc.
Circle Pines, MN 55014

Stregthening the Family
by H. Stephen Glenn

Potomac Press
Pacific Institute for Research & Evaluation
7101 Wisconsin Ave., Suite 1006
Bethesda, MD 20014

My God! My Teenagers Really Are Human Beings!

I really didn't believe it could be true. But after reading a 150-page book — *How To Live With Your Teenager* — written by Peter H. Buntman and Eleanor M. Saris — I found that the arguments and fights within my own home have calmed down — and my teenagers really are acting like human beings.

Buntman, a noted psychotherapist, and Saris, a mother of four teenagers, have written what others have called A Parent's Survivor's Manual. This volume is so very unique. But what it did for my family — is a wonder!

Friends who knew our family now say:

THEY REALLY DIDN'T BELIEVE THESE COULD BE MY KIDS

when they see them now. And it's all because of this 150-page "How To" guide.

What this book did for me is unbelievable. After reading it;

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American Lung Association Bulletin

THERE'S EVEN STRONGER EVIDENCE NOW ON THE HEALTH HAZARDS OF SMOKING

Jesse L. Steinfeld, M.D.

At the recent 3rd World Conference on Smoking and Health, Dr. Steinfeld summarized the recent scientific information on the health consequences of smoking. The scientific evidence is sufficient to establish cigarette smoking as the single most preventable cause of chronic obstructive lung disease, coronary heart disease, and lung cancer.

WITH ALL THE INFORMATION that has been disseminated about the harmfulness of smoking cigarettes, many youngsters continue to take up smoking, and many adults continue to smoke. This trend has led increasing numbers of health professionals to express dismay and alarm at what might seem to reflect some kind of failure on their part. But, I submit, this is not a failure of the medical and the health professions; it is a failure of society.

Where, for instance, is there a disease in the United States which has a $200 million advertising budget? It's certainly not pernicious anemia or pneumococcal pneumonia or any of the congenital, metabolic, nutritional, traumatic, infectious, or neoplastic diseases. Only alcohol shares with tobacco such great economic gains for its purveyors and great medical and social disasters for its users.

The tobacco merchants are quite content for scientists to do research on tobacco and to write and talk with one another about it. However, they become most upset when physicians and scientists urge social action. But social action is just what we must have.

I do not believe in the "gloom and doom" attitudes of many people concerned about the hazards of cigarette smoking. We have made great progress. Thirty million Americans have quit smoking. The average cigarette's tar and nicotine levels are respectively over 50 percent and 40 percent less than before the campaign against the

This scientist may understand atomic energy, but he is evidently ignoring the evidence on smoking.

Authenticated News

cigarette began just a decade ago. Four out of five smoking Americans have tried to quit smoking in the past ten years, and about 20 million were successful. We have made *significant* progress.

There is a final point I'd like to make before reviewing the medical data on smoking, and this relates to nonsmokers' rights. The campaign for the right of the nonsmoker to breathe pure air has upset the tobacco companies more than anything that has been done medically, educationally, scientifically, by legislation, or by government regulation. The reason for the tobacco merchants' concern is as simple as it is important: If smoking is unacceptable social behavior—relegated to bathrooms, poolrooms, and barrooms—then the cigarette will follow the spittoon to oblivion. But so long as smoking is regarded as a private form of slow suicide or self-pollution, it will be difficult to generate the societal forces needed to combat what is, after all, a societal problem.

The goal is not to reform sinners but to combat society's number one public health problem. We must marshal all possible social forces to achieve that goal.

Multiple adverse health effects

Ten years ago, the tobacco propagandists laughed at the early reports on the hazards of cigarette smoking. Following the report from the Royal College of Physicians in 1962 and the first U.S. Surgeon General's report in 1964, the tobacco company propagandists proclaimed, "Cigarette smoking causes everything from cancer, lung disease and heart disease to peptic ulcer—clearly these physicians and scientists are victims of a giant statistical hoax."

In recent years, however, scientists have been able to identify over 1,000 different chemical constituents in cigarette smoke. It is not so surprising that when an individual exposes himself to a thousand different chemicals, with all the possible interactions, synergisms and antagonisms, his body can be affected adversely in many ways.

The tobacco company-employed propagandists no longer laugh. Their scientists now are working to identify and hopefully remove the toxic and lethal components of cigarette smoke. Until they are successful, however, and can prove the safety of their product, our goal should remain to eliminate cigarette smoking from society.

THE HEALTH CONSEQUENCES

Cancer

Cigarette smoking is the number one cause of lung cancer in industrialized countries. The relationship between cigarette smoking and lung cancer holds for white, black, Japanese and Arabic populations. The greater the exposure to tar and nicotine, the greater the likelihood of lung cancer. This means that those who begin smoking at an early age, those who smoke more cigarettes, take more puffs, and inhale more are most likely to develop lung cancer. This dose-response relationship also holds for myocardial infarction and emphysema.

For all smokers, the risk of developing lung cancer compared with nonsmokers ranges from 7.6 to 14.2 times as great. For men who smoke heavily, the risk of developing lung cancer is 4.9 to 23.9 times that of the nonsmoker.

These, in brief, are some of the major findings identified to date concerning smoking and cancer:

People living in cities have a higher rate of lung cancer than those who live in rural areas, but the heavy smoker in the rural area has about the same chance of developing lung cancer as the urban dweller.

Cigar and pipe smokers also have a higher incidence of lung cancer than nonsmokers but not so high an incidence as cigarette smokers. However, in oral cancer, the pipe and cigar smoker runs about the same risk of developing the carcinoma as the cigarette smoker.

The smoker who inhales may absorb from his lungs into the blood stream any number of constituents of tobacco smoke. Cancer of the pancreas in both men and women and cancer of the urinary bladder in men are clearly increased in cigarette smokers.

Host defenses. Due to as yet unknown or undefined host defenses, many individuals exposed to disease-causing agents, whether it be the tubercle bacillus or cigarette smoke, do not develop disease. Scientists are now doing some investigative work on this matter.

Much has been learned about the growth rate and natural history of the several types of lung cancer over the past decade. It has now been established that the smoking material, the quantity smoked, and smoking behavior may all be related to the incidence of lung cancer. Equally important, people who stop smoking will, after seven or eight or even as long as 15 years, have a lung cancer incidence first approaching and ultimately equaling that of their nonsmoking cohorts.

Heart disease

Because coronary heart disease is the number one killer in the United States, much research has focused on the mechanisms by which cigarette smoking exerts its harmful effects. Carbon monoxide and nicotine affect the heart, the lungs, the aorta, and the smaller but nontheless important arterioles. It must be added that cigarette smoking is only one factor in the development of heart disease. Heredity, diet, exercise, and mode of living all play a part in its development.

These are some of the scientific facts on the relation of cigarette smoking to heart disease:

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Carbon monoxide. When the smoker inhales, he may take into his lungs as much as one to five percent of carbon monoxide in the gaseous phase of cigarette smoke. He may inhale an astonishing level of 10,000 to 50,000 ppm of carbon monoxide, to be diluted in his bronchi and alveoli before being presented to his pulmonary capillaries. These are levels of carbon monoxide many, many times those permissible in occupational exposure.

Synergism. From experimental studies, it is now suspected that the interplay of just two of the 1,000 or more components of cigarette smoke may be major culprits in the excess incidence of and mortality from coronary heart disease among cigarette smokers.

Hastens onset of angina. Recent careful studies have shown that carbon monoxide—whether from cigarettes or automobile exhaust—will hasten the onset of angina pectoris under controlled exercise conditions, with electrocardiographic monitoring. In my opinion, these experiments change the objecting passive smoker from a noisy crank to an individual concerned for his own, as well as his neighbor's, health.

Chronic obstructive pulmonary disease

The scientific information on the relation of chronic obstructive pulmonary disease to cigarette smoking is equally serious. Chronic bronchitis and emphysema, which are both included in the term "chronic obstructive pulmonary disease" (COPD), are about 18 times as common among smokers when compared with nonsmokers. Mortality rates from these diseases are 4 to 25 times those of nonsmokers.

Chronic bronchitis is a condition characterized by chronic, persistent cough and the production of excessive mucus by the bronchial mucous membranes. Emphysema refers to a destructive anatomic condition in which pulmonary air sacs, or alveoli, are destroyed and the distal air spaces become both large and functionally abnormal. Both these changes can be related to the number of cigarettes consumed.

The destructive changes in chronic bronchitis and emphysema are irreversible, although the ex-smoker does produce less mucus and has fewer of the acute changes associated with cigarette smoking. There is an inhibition of the ciliary activity of the bronchial lining in cigarette smokers' lungs, an increase in mucus production, an inhibition of phagocytic activity (the phagocytes take up inhaled particles), and an inhibition of production of pulmonary surfactant, the substance which keeps the alveoli open. Taken together, these changes result in destruction of pulmonary alveoli and reduced expulsion of inhaled foreign matter, whether from cigarette smoke or urban or industrial pollution.

Asthmatic attacks. Cigarette smoking also increases the frequency and severity of asthmatic attacks but does not significantly increase the death rate of asthmatics.

Authenticated News

Recent studies show that carbon monoxide—whether from cigarettes or autos—will hasten the onset of angina, under controlled exercise.

Chronic obstructive pulmonary disease patients taking breathing exercises. COPD is 18 times more common among smokers than among nonsmokers.

Arizona Lung Assn.

A REPORT ON THE 3RD WORLD CONFERENCE ON SMOKING AND HEALTH

THE WARNING FLAG about cigarette smoking has been up since the Surgeon General's Report, published in 1964. And research since that time has led to the firm conclusion that smoking is a leading cause of many of the worst diseases of our time: emphysema, chronic bronchitis, cancer, heart disease, and others.

Thirty million Americans have quit smoking. But other millions, mostly teenagers, aren't heeding the signal or haven't focused on it. Cigarettes are selling briskly in the United States and abroad, supported by ads showing young men and women smokers in blue jeans and expressions that say, "We decide for ourselves."

The feeling at the recent 3rd World Conference on Smoking and Health, held in New York City this June, was that it's not enough to try to get across the facts to the vast general public about the hazards of cigarette smoking. What's needed, instead, are programs to reach specific target groups. These include:

- Teenagers, particularly girls. The proportion of teenagers who smoke regularly, including those who smoke at least once a week, has increased from 12% in 1968 to 16% in 1974. This increase has taken place almost exclusively among girls. By the time a boy or girl is 18, about one in three is a smoker.
- Pregnant women. Smoking is said to account for five percent of the stillbirths in the United States. The risk is tied to low birth weight; the risk increases with the number of cigarettes smoked daily by the pregnant woman.
- Children in their early formative years, kindergarten to third grade. The ALA is leading in the development of teaching units on health education, including cigarette smoking, for incorporation into the school curriculum.
- Health professionals. People in this group need to strengthen their stand against smoking. They play a highly visible and important role in influencing people to smoke or not smoke.

In response to the increasing evidence that exposure to tobacco smoke is aggravating and sometimes harmful to nonsmokers, a conference work group also recommended that, through voluntary and legislative measures, smoking be banned in all public places, including places of employment. "Nonsmokers should always have the right to work in smoke-free areas."

Other means of positive social action were proposed.

- Voluntary health organizations, professional medical associations, and other organizations concerned with health were urged to set an example by prohibiting smoking in their offices, conferences, and workshops.
- It was also recommended that hospitals set a policy of no smoking for medical and nursing staff and visitors, with segregated areas set aside for other hospital staff, away from the view of patients and health professionals. It was further recommended that all schools which train physicians, nurses, and other health professionals develop course materials on smoking and health and methods for helping people stop smoking.
- Business, industry, and labor unions were urged to provide health education programs on the hazards of cigarette smoking, including information on nonsmokers' rights. Employers were asked to give employees time off with pay to attend smoking withdrawal programs.
- Government-funded and private health insurance programs covering, at least in part, the cost of smoking treatment services for their clients were recommended. In addition, the conferees urged government regulation to document the effectiveness of the many stop-smoking clinics.

A psychiatrist who is a leading expert on drug addiction emphasized that tobacco addiction does exist. Jerome H. Jaffe, M.D., of New York State Psychiatric Institute and Hospital stated at the conference that with each cigarette, "the pharmacological effect strengthens the tendency to continue the drug [nicotine] use."

Dr. Jaffe urged that a distinction be made between tobacco use and abuse. Smoking more than a pack a day should be labeled a disorder, he said. He proposed the label "compulsive smoking syndrome," suggesting that such a term would diminish the social acceptability of the habit.

—LUCILLE FISHER

The 3rd World Conference on Smoking and Health was sponsored by the American Cancer Society and the National Cancer Institute, in cooperation with ten major health organizations, including the American Lung Association. Five hundred delegates from 47 countries attended the conference.

Pipe and cigar smokers have less chronic obstructive pulmonary disease than cigarette smokers.

The quality of life is affected, even in those cigarette smokers whose disease is not symptomatic. The changes show up as more frequent and more severe respiratory infections, as well as the more numerous postoperative complications. These changes occur in both men and women.

It does not take years for cigarette smoking to affect, lung function, contrary to earlier belief. High school students who smoke cigarettes regularly can be shown to have impairment of pulmonary function, though not to

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APHA

What's needed are programs to reach specific target groups, members of the 3rd World Conference stated. Among the targets are teenagers—especially young women—and also health professionals who smoke.

Other means of positive social action include setting no-smoking policies for hospital staff members and encouraging business and industry to provide smoking education programs for their employees.

CIGARETTES
ARE NOT AVAILABLE
IN HOSPITAL

Florida Lung Assn.

Washington Lung Assn.

the degree shown by the smoker of 20 years' duration.

Cause of COPD mortality. Although occupational or urban exposure to pollutants can act either additively or synergistically with cigarette smoke as causative agents in chronic obstructive pulmonary disease, cigarette smoking is by far the most significant cause of COPD mortality, not only in the United States population but in Canada, Great Britain, and Ireland. Morbidity associations have been shown in the United States, United Kingdom, Canada, Finland, Sweden, and Japan.

Among people who die of accidental causes, autopsy investigations have much more frequently shown the histologic consequences of COPD in smokers as compared to nonsmokers. There is an increase in goblet cell density, thickened bronchial epithelium, and mucous gland hypertropny in the smoker's lungs.

There is a rare genetic error, homozygous alpha, antitrypsin deficiency, which occurs in one out of 3,600 people in the United States. This is associated with early development of panacinar emphysema. Whether smoking contributes to the early development of emphysema in those groups has not been definitely established.

Cessation of cigarette smoking results in lower death rates from COPD, improved pulmonary function, and a decrease in pulmonary symptoms. This results not from a repair of destroyed alveoli but rather from the removal of toxic agents which increase mucus production, inhibit ciliary function, and produce other untoward effects. Even without repair of alveoli, cessation of smoking leads to improvement in quality and quantity of life.

Less hazardous means of smoking includes the use of filter-tip cigarettes, which are associated with less cough and less sputum than regular cigarettes. The cigarette smoker who keeps the cigarette in his mouth between puffs is more likely to develop respiratory symptoms than the cigarette smoker who removes the cigarette between puffs.

The pulmonary invalid suffers for a longer period of time—breathless, unable to fend for himself, coughing constantly—than either the heart attack or lung cancer victim.

Overall, the current epidemic of chronic obstructive pulmonary disease shows no signs of diminishing, and cigarette smoking is the major cause of the disease.

Pregnancy and smoking

Lower weight babies. Although there were early reports of injurious effects on the fetus associated with maternal smoking, the most significant of the reports came from the British Perinatal Mortality Survey. This extensive survey showed a 170-gram difference in mean birthweight between children born to mothers who smoked after the fourth month of pregnancy and children born to nonsmoking mothers. The lower weight babies were also one-half-inch shorter than those of nonsmoking mothers. Findings in the United States and France are similar to the British studies.

One probable cause for the decrease in fetal weight among smoking mothers is the presence of excess carbon monoxide in the mothers' blood. Carbon monoxide crosses into the fetus from the maternal circulation. It has been repeatedly shown that fetal carboxyhemoglobin is up to ten times as high in infants born of smoking mothers, as infants born of nonsmoking mothers. Hypoxia, similarly, has been shown to exert an adverse effect on fetal birth weight of infants born to mothers living in high altitudes. Autopsies of fetuses of mothers who have died of carbon monoxide poisoning have shown unequivical anatomic central nervous system damage. There may be a complex interplay of other factors in cigarette smoke which affect fetal development.

There is an increase in stillbirths, as well as an increase in the death rate among newborn babies of smoking mothers. Various estimates of the increased fetal and infant mortality for smoking mothers range from 28 percent to 60 percent to as high as 100 percent in a small and selected sample. Smoking mothers in lower socioeconomic groups are in the higher ranges of risk.

The developing fetus is the most sensitive of biologic phenomena. To expose this intricate evolutionary miracle to poisons wantonly and deliberately, in my opinion, is creating an unhealthy environment for a developing human being.

Passive smoking

Until ten years ago, little attention was paid to the effects of tobacco smoke upon the nonsmoker because the health hazards of smoking cigarettes had not been clearly delineated. In the past decade, there has been some investigation of the physiological and pharmacological effects of cigarette smoke upon those who unwittingly and involuntarily are exposed to the products of tobacco smoke. It will undoubtedly take a number of years to collect more data regarding the effects of tobacco smoke upon the nonsmoker, but there is much we already know.

Sidestream smoke. Several recent studies indicate that a number of compounds found in cigarette smoke are produced in higher quantities in the sidestream smoke from the burning of the cigarette as compared with the mainstream smoke which is inhaled by the smoker. There is four times as much carbon monoxide in sidestream smoke as in mainstream smoke, and this is true for several of the other harmful constituents in cigarette smoke, such as the tars. As the cigarette is smoked more and more, there is a greater proportional production of carbon monoxide.

Many of the rooms in which we work or in which we hold meetings or conferences and the automobiles in which we drive have a very low rate of exchange of air, and in some instances there's none at all. This contributes to levels of carbon monoxide that are well above those found to be hazardous for working conditions by both the U.S. Department of Labor and the U.S. Environmental Protection Agency. The level of carbon monoxide in smoke-filled rooms varies from 20 to 80 parts per million.

Other contaminants. It is not only levels of carbon monoxide which may be hazardous. Sidestream cigarette smoke condensate may contain up to three times as much benzo(a)pyrene as mainstream smoke and may contain up to three times the level of tars as well as significant amounts of nicotine. Another group of contaminates are the nitrous oxides which are present in smoke-filled rooms. These compounds are quite toxic to the lung.

The hemoglobin tied up by carbon monoxide may increase 500 percent in an individual exposed to a smoke-filled room or automobile. This level of carboxyhemoglobin can lead to serious impairment of health in the individual who already has cardiac or pulmonary disease. Angina, for example, is precipitated by less exercise following passive smoking than after breathing pure air. Studies show that psychomotor function, such as the ability to discriminate sound levels or the ability to distinguish relative brightness, can be impaired by these levels of carbon monoxide. So can the ability to coordinate muscular function, such as "putting on the brakes rapidly."

Air quality standards. Although I have been emphasizing the health hazards of carbon monoxide, it is quite clear that the level of particulate matter in enclosed areas where people are smoking is of great concern. Smoke-filled rooms and smoke-filled automobiles are clearly in violation of standards for pure air quality set by various agencies of the United States government.

Other people's discomfort. Individuals suffering from chronic heart and lung disease are not the only victims of cigarette smoke. A significant portion of our population is allergic to one or another compound, and even nonallergic nonsmokers report discomfort and respiratory symptoms when exposed to tobacco smoke. Tobacco smoke can precipitate allergic attacks, headaches, eye irritation, nasal symptoms, cough, and wheezing in addition to raising the levels of carboxyhemoglobin in the individuals exposed to smoke-filled rooms.

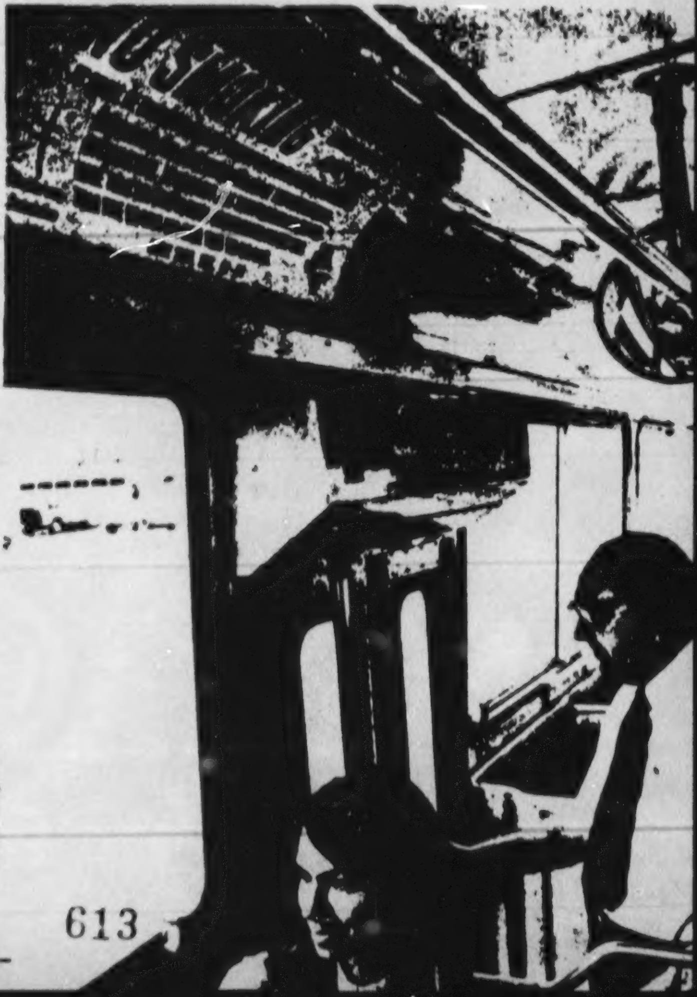
Summary

In summary, in the industrialized nations, cigarette smoking is the greatest single cause of excess morbidity and mortality from lung and other cancer, from heart attacks, and also from emphysema in both men and women. That statement is based upon careful epidemiologic and pathologic studies in humans, buttressed by extensive experimental studies in animals.

Until research can provide a cigarette which is truly harmless and from which the toxic components are removed, society's goal must remain the cessation of smoking to improve the quality and quantity of life for both men and women—for both smokers and nonsmokers.

The time has come when our goal can no longer be simply to protect the smoker from himself. The time has come to protect ourselves from the smoker. We will all benefit. We'll enjoy the Nonsmokers' Bill of Rights together. ■

It's the law in Jacksonville. The no-smoking sign on the bus was provided by the Florida Lung Association.



Florida Lung Assn.

The above article was condensed from a longer report delivered at the Third World Conference on Smoking and Health, held in New York City in June. Jesse L. Steinfeld, M.D., was formerly U.S. Surgeon General. He is now chairman of the Department of Medicine of the Veterans Administration Hospital in Long Beach, Calif., and professor of medicine, University of California, Irvine, Calif.

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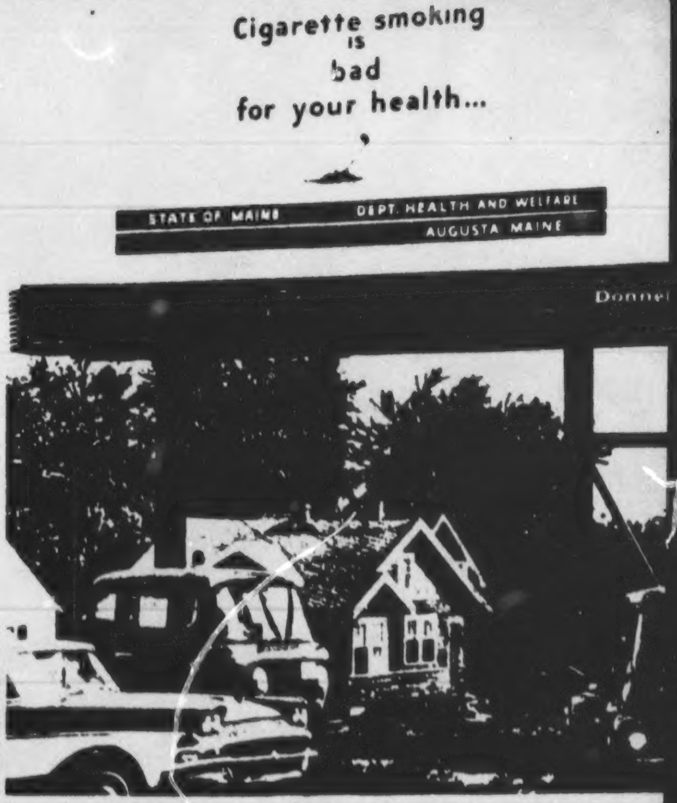
There's a growing movement to recognize the non-smoker's discomfort in public places like restaurants.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The State of Maine says it in no uncertain terms on this big highway sign.

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MARIJUANA SMOKING— A NATIONAL EPIDEMIC

Robert L. DuPont, M.D

Cannabis sativa is slowly shedding its disguise as a harmless amusement. Sixteen million Americans use it regularly, despite mounting scientific evidence indicting marijuana smoke as a threat to brain function as well as a respiratory hazard perhaps more dangerous than tobacco.

MARIJUANA SMOKING constitutes the greatest single new threat to the health of our lungs in the United States. In the next ten years, the potential exists for an enormous worsening of the respiratory health of Americans, unless we do something about it now.

Marijuana is a new problem in American society. Twenty years ago, virtually no one used it. As recently as 1962, only 1% of American youth aged 12 to 17 and 4% of Americans aged 18 to 25 had ever tried marijuana. By 1979, these figures had risen to 31% and 68%.

The drug explosion did not begin with marijuana—but rather with LSD in the 1950's. Not until the late 60's did marijuana start to come into vogue, and smoking it did not become commonplace until the middle 1970's. Today, marijuana consumption is continuing to increase at a rapid rate.

One of the curious things about marijuana is that the health effects of smoking it are weighed on a different scale from other health risks in our population. Most new drugs are considered dangerous until proven safe. For marijuana, the assumption has been the reverse: It has been assumed to be safe until proven harmful. The common wisdom in the early 1970's was that using the drug was not serious. John Lennon, who has a way with words, called it "a harmless giggle." In 1974, the National Commission on Marijuana entitled its first report to the American people, "Marijuana: A Signal of Misunderstanding," telling us with their title that the problem with marijuana was not the drug but society's response to it.

A national epidemic

Today, marijuana smoking is a national epidemic. Forty-four million Americans have smoked it at least once. Sixteen million Americans are currently regular smokers of the weed. Four million young people of 17 years and under are at present smokers. Among the nation's ninth graders, the percentage of students who have smoked it jumped from 16% in 1975 to over 32% in 1979. Among high school seniors, slightly less than 11% smoke it every day, and the average number of joints smoked by those seniors is 3½ a day.

Substances used most commonly on a daily basis by high school seniors are tobacco, marijuana, and alcohol. Among high school seniors, 29% use tobacco daily, roughly 11% use marijuana every day, and 6% use alcohol daily. Those percentages of daily tobacco and alcohol users have remained the same since 1975, while the proportion of daily marijuana users has doubled in that period. There is certainly no other illegal drug that compares with marijuana in terms of frequence of usage.

The extent of marijuana usage in the United States comes more clearly into focus when you compare it with the experience of other countries with the habit. Most people are aware that marijuana has been smoked around the world for a long time. However, you may not know that American young people are literally the only population in the history of the world in which large numbers of an entire generation have smoked marijuana; experience with the cannabis product (it comes from the cannabis sativa plant) is restricted in other parts of the world. The use of marijuana in other countries does not involve an entire society; generally, its use is limited to either religious groups or social classes that are relatively isolated and generally looked down on in the society.

How we got into the mess

Something new and dramatic has happened that may

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ROBERT L. DUPONT, M.D., is president of the American Council on Marijuana and a former director of the National Institute on Drug Abuse. A practicing psychiatrist, he heads Washington, D.C.'s first phobia treatment program and writes on health topics for local and national television, radio, magazines, and newspapers. He is also president of the non-profit Institute for Behavior and Health, which conducts research and demonstration programs aimed at preventing drug and alcohol abuse.

Eric Kroll

Four million young people of 17 and under – including nearly 11% of high school seniors — can be counted as frequent marijuana smokers. "It's part of the scene, like blue jeans," claims one teenager.

affect the growing acceptance of marijuana in the United States. Scientists have identified some of the hazardous effects of marijuana smoke on the body.

Before I discuss those new findings, let me talk about how we got into the mess we are in with marijuana; it will reveal some of the challenges that we must meet.

The first thing to realize about the drug is that it does work—it produces powerful effects. The major psychoactive agent is THC (delta-9-tetrahydrocannabinol). Ten years ago, the average THC content in a marijuana cigarette was 2/10 of a percent. Today, it's more like 4% or 5%. That's an increase of 20 to 25 times in the last six or seven years.

The second point is that marijuana is unique in that it has been a potent symbol. It has been a symbol of youth, a symbol of anti-authority positions, a symbol of modernity.

There has also been a unique tendency to trivialize the marijuana experience, and this is truly frightening to people who are aware of the effects of marijuana on the body. As one high school student said to me a year or so ago, "Marijuana is not a drug. It's part of the scene, like blue jeans." This remark represents the evolution of an attitude from the days ten years ago when marijuana was a meaningful symbol to its present status as "part of the scene."

Reasons why it has been accepted

Now, one might ask why there are 16 million people regularly smoking a new substance which society would ordinarily resist. I want to outline some of the reasons for this. First, there is a history of exaggerations in the past about the harmfulness of marijuana, based on little or no data. This has been captured by pro-marijuana lobbyists with a 1930's film called "Reefer Madness." The message is a putdown for anyone who has anything bad to say about marijuana.

Second, the decriminalization of marijuana use has led to greater acceptance. Over half of the public attention devoted to the issue in recent years has focused on the criminal sanctions for possession. Much of the debate is symbolic: If you are for decriminalization, you are for marijuana. If you're against decriminalization, you're against marijuana use.

The reality is that virtually no one in the United States is sent to jail for possession of the product any more. There are still about 400,000 arrests for marijuana possession a year, but the offenders are rarely prosecuted. Those who are prosecuted are virtually never sent to prison. In fact, the current approach of the criminal law towards marijuana makes it difficult to find any instance of prosecution even for the sale of marijuana at the federal level. In general, possession with intent to sell must be demonstrated to trigger an indictment. The concept that we need to reform our laws to deal with the marijuana possessor is unreasonable when viewed against the realities of the present enforcement attitude.

The third reason why marijuana has been accepted lies in the charge of parental or adult hypocrisy. The idea is that, because adults smoke cigarettes or drink alcohol, kids ought to be able to smoke marijuana. Therefore, if adults condemn marijuana smoking, they are being hypocritical.

The answer to the parental or adult hypocrisy charge is that decisions about the use of a psychoactive substance—whether it be marijuana, alcohol or tobacco—should be made by adults and not by children. Even Keith Stroup of the national marijuana lobbying organization opposes the use of cannabis, as well as tobacco and alcohol, by people under the age of 18.

As a society, we pay $45 billion a year in social costs to let every citizen set his or her own consumption level of alcohol. The social costs include damage inflicted in auto accidents, treatment of alcoholism, extended health care, and the economic results of decreased productivity. It soaks up another $25 billion a year to afford tobacco the same privilege. Adding a third drug to that list, in the light of these consequences to our society, is hardly supportable.

The therapeutic use argument, another red herring

The fourth red herring that has been drawn across the path of anyone trying to do something about the marijuana epidemic is the therapeutic-use argument. Twenty state legislatures in the past year have been bamboozled into passing laws to legalize the use of marijuana as a medicine. The legislation is unnecessary; there are federal statutes that make marijuana available as a medication, if it were ever to pass muster as a clinically effective agent for any specific ailment. In my opinion, that possibility is extremely unlikely.

Marijuana is not a chemical, it is a vegetable plant product. It contains over 400 separate chemicals, 60 of them unique to the cannabis sativa plant and known as cannabinoids. When marijuana is smoked, it emits more than 4,000 separate, identifiable chemical substances. The idea of treating any disease with something so complex is unmedical and unscientific. It is a little like saying, "We'll have people eat bread mold to treat pneumococcal pneumonia instead of using penicillin."

At the same time, some of the components of marijuana—and particularly THC—may have some therapeutic use. I certainly favor the investigation of those components, but we do not need any new laws for that. My point is that if marijuana is treated as a helpful medicine, it will gain acceptability in terms of public perception. That is why marijuana lobbyists are so vigorously promoting the use of marijuana for glaucoma sufferers and those who are undergoing chemotherapy for cancer.

United Press International Photo

With the approval of medical authorities, some glaucoma sufferers legally puff "grass" to relieve the condition. The author says this is like treating pneumonia patients with bread mold instead of penicillin.

They don't want doctors to use purified chemicals such as THC, because they lose their symbolic argument.

Why the public has not been warned

The next point I want to make, and this may be more controversial, concerns what I consider to be the failure of our nation, including the scientific experts, to properly warn the public about the dangers of marijuana. One reason for this may lie in the relatively low level of sophistication of many of the initial studies of the drug's effects. There were, for example, three studies of chronic marijuana smokers abroad in which heavy user populations were compared to non-using populations. Relatively little difference in health was found between the two groups.

Two facts must be brought out. First, the total number of subjects in all three studies was less than 130 people, including the experimental and control groups. Second, there was an effort made in each investigation to identify healthy people and exclude unhealthy ones from the sample.

If you were to examine the effects of tobacco on just 130 cigarette smokers, ruling out any sick ones, you would not establish a significant difference between smokers and nonsmokers. That is essentially the way many of our inquiries into marijuana have been carried out. And yet, the results have been reported as showing marijuana is safe. In addition, the early studies of marijuana's health effects used marijuana with only ½% of THC compared to 4% or 5% of THC in today's marijuana.

It is clear that the study of the health effects of drugs is quite complex, especially as many negative results take a long period of time to surface. It takes a great deal of highly sophisticated research over many years to identify problems associated with chronic drug use.

Researchers also affected by society's attitude

Finally, it seems to me that the marijuana researchers have been caught with the rest of us in the complex and often misleading historical process. Those investigators who are university-based, where the attitudes toward marijuana have been relatively positive, have found it more difficult to expose the hazards of cannabis than to say that the evidence against it is exaggerated.

As an example, I have a sociologist friend who completed a study based on national data that not only correlates marijuana use highly with heroin use but also shows that marijuana would actually pass the test of *causing* heroin use. When he published his paper, he tacked on an extra three paragraphs saying that perhaps this happens because marijuana is an illegal drug bought

So we have evidence that marijuana contains more tar and known carcinogens than tobacco. Moreover, when human and animal lung tissue are exposed to marijuana smoke in a laboratory setting, the resulting cancerous changes are analogous to those produced by tobacco smoke and, in some cases, more frequent. Finding evidence on the development of human lung cancer from marijuana smoke is, I think, just a matter of time.

The evidence piles up

There is yet more evidence that indicates harmful respiratory complications from marijuana use. Some studies have shown severe inflammation of the small airways. Others have demonstrated that the alveolar macrophages, the primary defense against alien bodies in the lungs, are less able to dispose of bacteria and foreign materials when exposed to marijuana smoke.

In addition, there is a rise in the carboxyhemoglobin level in the blood—an increase in the ratio of carbon monoxide to oxygen. One study found that a single marijuana cigarette smoked for 15 minutes produced as high a level of carboxyhemoglobin as ten to twenty tobacco cigarettes smoked in the course of a day. I think the likeliest reason for this difference is the way marijuana is smoked.

So, the evidence suggests that smoking marijuana is harmful to the lungs. Furthermore, everything we now know about the effects of tobacco smoking is applicable to marijuana use in terms of what it does to the lungs—at least, one ought to begin with that assumption until there is evidence to the contrary. We obviously need broad-based epidemiological studies before the final "i" is dotted in this indictment, but I don't know how anyone can believe that marijuana is harmless to lungs in the light of the available data.

Effects of the drug on other parts of the body

Let me cover very briefly the effects of marijuana on other organs of the body. It is important to know that the intoxicating effect of marijuana is profound. The consequences are in some ways like those of alcohol, being of several hours' duration. However, alcohol is soluble in water, and because of this, the water-based waste disposal system of blood and urine works quite well to get rid of it. THC, not being water-soluble, tends to be retained in the body, particularly in the brain and the reproductive organs.

A person who smokes one marijuana cigarette has half of the THC in his body five to seven days later, and measurable quantities are present after a month. This means that if a person smokes as infrequently as once a month, the THC accumulates, and the brain and reproductive organs are continuously exposed. There is good evidence that there are profound effects both on brain function and reproductive function from marijuana use.

Hard to reverse the tide

It has proved difficult, even with all the data available in recent years on the health hazards of tobacco smoking, to convince Americans—and especially young people—to quit the cigarette habit or never start it.

Those of us in the marijuana field have found it even harder to turn the tide of the marijuana epidemic because of the perceived lack of sufficient scientific evidence on the dangers of marijuana. This information is just beginning to come to light. As a result, many young people—who make up the majority of marijuana users—have seen no reason not to smoke pot.

Among American high school seniors, about 60% perceive that there is a great health risk in cigarette smoking. Only 35% see the similar peril of cannabis sativa. It is that disparity which is contributing to the explosive growth of marijuana smoking. *The Washington Star* quoted a young man who was interviewed about his opinion of the new evidence regarding the health hazards of marijuana. He said, "I know it would be good for my health to quit and that I would save money, but they haven't come up with a good argument yet to get me to stop smoking pot."

The most bizarre thing that strikes me about young people is that so many are concerned about pollution, worried about the environment, believers in eating natural foods, crusaders against the problems of nuclear energy—and yet they continue to smoke marijuana cigarettes. The idea that smoking pot may be hazardous to your health just hasn't cut through all the controversy and the politics surrounding the weed. There is a growing body of information about health risks, and we need to get that across.

I would add that scientific data on the health effects of any drug or product is not, in itself, sufficient to solve the public health problem. However, it is a necessary condition for public health mobilization.

It is actually within only the past year or two that some initial findings on the changes in the body produced by marijuana smoking have been developed. I am convinced that if marijuana smoking were to be taken up as a priority by the American Lung Association, we would take a giant step forward in the education of the public about cannabis.

Smoke is bad for the lungs, whether it's industrial smoke, tobacco smoke or marijuana smoke. We need your help in stemming the marijuana epidemic. «

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